

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13267

CERTIFICATE OF DEATH

14351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P. O. Box 75, Church Creek</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>09X-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertie Akon</u> Middle _____ Last _____		4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE (In years lost birthday) yrs. <u>58?</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Riney Brannoch</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Brannoch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia and Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Cardiovascular accident</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain syndrome associated with generalized arterio</u> <u>sclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct. 10,</u> 19 <u>59</u> , to <u>Dec. 31,</u> 19 <u>59</u> that I last saw the deceased alive on <u>Dec. 31,</u> 19 <u>59</u> and that death occurred at <u>10:45 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ludwig Benedict</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Field</u>	22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Hoffman</u>		24a. RECEIVED BY REGISTRAR DATE <u>JAN 7 '60</u>	
ADDRESS <u>Cambridge, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

13281

CENTRAL OF DEATH

13281

13281
CENTRAL OF DEATH
13281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

13268

Items 12.23 FilmG254 1-20-60 et

CERTIFICATE OF DEATH

13221

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> <u>Jessups</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u> <u>Jessups</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>				c. LENGTH OF STAY IN 1b <u>47 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jessups</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>VAITEKUS</u> Middle <u>BARONAS</u> Last <u>BARONAS</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1867</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>??</u>				13. FATHER'S NAME <u>Heckman</u>			
14. MOTHER'S MAIDEN NAME <u>Heckman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>480x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Influenza</u> DUE TO (c) <u>Gen'l Arterio-sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 wk</u> <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>TOTAL SENILE DEMENTIA</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/20</u> , 19 <u>59</u> , to <u>12/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/27/59</u> , 19 <u>59</u> , and that death occurred at <u>3:00</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J M Warren</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Laurel Md 12/1/59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/2/59</u>		<u>Meadow Lodge Cemetery, Dorsey</u>		<u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Max W. Wachuska</u>				ADDRESS <u>637 West Blvd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

CERTIFICATE OF DEATH

12345

NAME OF DECEASED JOHN DOE		SEX Male		AGE 45		DATE OF BIRTH 10/15/1910		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Teacher		MARITAL STATUS Married		DATE OF MARRIAGE 08/12/1935		PLACE OF MARRIAGE Baltimore, Md.		NAME OF SPOUSE Jane Doe	
CAUSE OF DEATH Heart Disease		PLACE OF DEATH Home		DATE OF DEATH 05/20/1955		TIME OF DEATH 10:30 AM		SIGNATURE OF PHYSICIAN J. Smith	
SIGNATURE OF DECEASED (If living)		SIGNATURE OF WITNESS J. Doe		SIGNATURE OF PHYSICIAN J. Smith		SIGNATURE OF CLERK M. Jones		SIGNATURE OF REGISTRAR R. Brown	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.01, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.02.

13269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 551 Shipley Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle H. Last Berry				4. DATE OF DEATH Month 7 Day 24 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1871	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafarer (ret.)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Berry				14. MOTHER'S MAIDEN NAME Mary Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-16-7413			
17. INFORMANT Mary L. Smith				Address 551 Shipley Rd. Linth. Hgts.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from March 28, 1957 to Dec. 27, 1959 , that I last saw the deceased alive on Dec. 26, 1959 , and that death occurred at 4:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George A. Knipp				ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 12/28/59			
PHYSICIAN'S NAME (Type) George Knipp, M.D.				ADDRESS 4116 Edmondson Avenue			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12'30'59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue			
24a. REC'D BY REGISTRAR DEC 30 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13236

CERTIFICATE OF DEATH

Reg. Dist. No.

13223

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROY Middle EUGENE Last BEST		4. DATE OF DEATH Month 12 Day 9 Year 19 59	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 June 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader		10b. KIND OF BUSINESS OR INDUSTRY Electric Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME HENRY BEST		14. MOTHER'S MAIDEN NAME MARY SUDDATH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577 05 0562	
17. INFORMANT Mrs. Dorthoy May Epstein (Daughter) 119 Alameda Parkway, Arnold, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO HEPATIC COMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melastatic Carcinoma Prostate DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Days 10 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-4-59 , 19 59 , to 12-9 , 19 59 , that I last saw the deceased alive on 1045 , 19 59 , and that death occurred at 1105A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sylvan Busch		ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.	
DATE SIGNED 12-9-59			
PHYSICIAN'S NAME (Type) SYLVAN BUSCH LT MC USN		U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR DATE DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1
FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13224

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ft. Smallwood Rd., Box 301		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JACOB A. BLUHM		4. DATE OF DEATH December 4, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1885
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Baking	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Adolph Bluhm		14. MOTHER'S MAIDEN NAME Louisa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Ruth Bluhm Box 301 Rt. 8, Pasadena, Md.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED 12/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Dec. 7, 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		22d. LOCATION (City, town, or country) (State) Frederick Rd. Balto., Md.	
23. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy. (25)		24a. REC'D BY REGISTRAR DATE DEC 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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NEW YORK
JAN 10 1951

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John F. Kennedy

John F. Kennedy

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John F. Kennedy

CERTIFICATE OF DEATH

13225

Reg. Dist. No.

13237

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 124 Charles Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Eveline Middle Green Last BOWERS				4. DATE OF DEATH Month 12 Day 5 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 January 1878		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard Green				14. MOTHER'S MAIDEN NAME Harriet Kent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Richard H. BOWERS 6128 32nd Place N.W. Wash. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Dec , 19 59 , to 5 Dec , 19 59 , that I last saw the deceased alive on 5 Dec , 19 59 , and that death occurred at 10: P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Annapolis, Md. DATE SIGNED 12-6-59							
ACTUAL SIGNATURE W. F. KRONE JR. LT MC USNR				M.D. U.S. Naval Hospital, Annapolis, Md. 12-6-59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec 10-59		Naval Academy		Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Sons				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE DEC 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13226

Reg. Dist. No.

13238

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>		d. STREET ADDRESS <u>Arundel Beach Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Garnett Lyle</u> First <u>Bowie</u> Middle Last		4. DATE OF DEATH <u>Dec 1</u> Month Day Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11-1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NSA</u>	11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Wm. Jeonett</u>	
14. MOTHER'S MAIDEN NAME <u>Beckley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>120</u>	
16. SOCIAL SECURITY NO. <u>577-10-6825</u>		17. INFORMANT <u>Son: Homer Bowie</u> Address <u>Severna Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Deterioration</u> 155.1 DUE TO <u>Generalized Carcinomatosis</u> (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u>Bladder</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , 19, to <u>1959</u> , 19, that I last saw the deceased alive on <u>11-30-59</u> , 19, and that death occurred at <u>1:14</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>12-1-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>		<u>Severna Park md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Lee, Mgr.</u>		ADDRESS <u>ARLINGTON, VA.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13239

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle GARFIELD Last BRICE		4. DATE OF DEATH Month December Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 18, 1881
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY General Com-Md	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George H. Brice		14. MOTHER'S MAIDEN NAME Ida Stinchcomb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, give war or dates of service		16. SOCIAL SECURITY NO. INFORMANT Mrs Wayne L. Graham Address Severn Ave Annapolis Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chn. congestive failure + u R 1 + 2 per INTERVAL BETWEEN ONSET AND DEATH 3 d			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to 12-26-59 , that I last saw the deceased alive on 12-25-59 , and that death occurred at 2:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M Shipley M.D.		ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Md. DATE SIGNED 12-26-59	
PHYSICIAN'S NAME (Type) Frank M. Shipley		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 29-59	22c. NAME OF CEMETERY OR CREMATORY St Margarets Cem	22d. LOCATION (City, town, or county) (State) St Margarets P.O. Md
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		24a. REC'D BY REGISTRAR DEC 30 '59	
ADDRESS Annapolis Md		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1328

CERTIFICATE OF DEATH

1328

NAME OF DECEASED: *James Edward*
AGE: *35* YEARS
SEX: *Male*
DATE OF DEATH: *Jan 10 1910*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
SIGNATURE OF PHYSICIAN: *Dr. J. H. Smith*
SIGNATURE OF WITNESSES: *John Doe, Jane Doe*
LOCAL HEALTH OFFICER: *Wm. H. Jones*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13228

13271

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>1mo. 5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>2103-2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>209 W. Bethel Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Burnett</u> Last <u>Burnett</u>				4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1876</u>		9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>023X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Syphilitic Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. - - - 19 - - - p. m. - - -		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <u>11/16</u> , 19 <u>59</u> , to <u>12/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/21</u> , 19 <u>59</u> , and that death occurred at <u>9:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u>		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>12/21/59</u>					
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M. D.</u>		<u>Crownsville State Hospital, Md.</u> <u>12/21/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 24 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John K Watson of Hagerstown</u>				ADDRESS <u>911X</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13229

Reg. Dist. No.

13272

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) e. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bacontown</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) <u>Edith</u> First <u>Wally</u> Middle <u>Bussell</u> Last				4. DATE OF DEATH <u>Dec</u> Month <u>12</u> Day <u>19</u> Year			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January</u> - 1900			
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTH PLACE (State or foreign country) <u>New Kent - Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>RICHARD Tyler</u>			
14. MOTHER'S MAIDEN NAME <u>LORETTA BANKS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>579-32-735</u>				17. INFORMANT <u>Rogers Bussell (husband)</u> Address			
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>260X</u> DUE TO <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Hustave H. Faubert</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/1/59</u>							
EXAMINER'S NAME (Type) <u>HUSTAVIE H. FAUBERT</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beacon Chapel</u>			
22d. LOCATION (City, town, or county) <u>Laurel, A A Co. Md</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby, 1200 Snowden Place, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF INTERMENT		20. SIGNATURE OF RECORDS		21. SIGNATURE OF ARCHIVES		22. SIGNATURE OF VITALS		23. SIGNATURE OF STATISTICS		24. SIGNATURE OF REPORTS		25. SIGNATURE OF CERTIFICATES		26. SIGNATURE OF DEATHS		27. SIGNATURE OF MARRIAGES		28. SIGNATURE OF DIVORCES		29. SIGNATURE OF SEPARATIONS		30. SIGNATURE OF ADULTERY		31. SIGNATURE OF FRAUDS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF NOTES		34. SIGNATURE OF COMMENTS		35. SIGNATURE OF REMARKS		36. SIGNATURE OF OBSERVATIONS		37. SIGNATURE OF FINDINGS		38. SIGNATURE OF CONCLUSIONS		39. SIGNATURE OF RECOMMENDATIONS		40. SIGNATURE OF SUGGESTIONS		41. SIGNATURE OF ADVICE		42. SIGNATURE OF INFORMATION		43. SIGNATURE OF DATA		44. SIGNATURE OF FACTS		45. SIGNATURE OF EVIDENCE		46. SIGNATURE OF PROOFS		47. SIGNATURE OF TESTIMONY		48. SIGNATURE OF VERIFICATION		49. SIGNATURE OF CONFIRMATION		50. SIGNATURE OF VALIDATION		51. SIGNATURE OF AUTHENTICATION		52. SIGNATURE OF CERTIFICATION		53. SIGNATURE OF REGISTRATION		54. SIGNATURE OF RECORDING		55. SIGNATURE OF INDEXING		56. SIGNATURE OF CODING		57. SIGNATURE OF CLASSIFICATION		58. SIGNATURE OF CATEGORIZATION		59. SIGNATURE OF SUBCATEGORIZATION		60. SIGNATURE OF DETAILING		61. SIGNATURE OF SPECIFICATION		62. SIGNATURE OF IDENTIFICATION		63. SIGNATURE OF DISCERNMENT		64. SIGNATURE OF RECOGNITION		65. SIGNATURE OF KNOWLEDGE		66. SIGNATURE OF UNDERSTANDING		67. SIGNATURE OF APPREHENSION		68. SIGNATURE OF PERCEPTION		69. SIGNATURE OF SENSATION		70. SIGNATURE OF FEELING		71. SIGNATURE OF EMOTION		72. SIGNATURE OF PASSION		73. SIGNATURE OF INTENSITY		74. SIGNATURE OF VIBRANCY		75. SIGNATURE OF LUMINOUS		76. SIGNATURE OF BRILLIANT		77. SIGNATURE OF GLEAMING		78. SIGNATURE OF GLAZED		79. SIGNATURE OF GLASSY		80. SIGNATURE OF GLASSY		81. SIGNATURE OF GLASSY		82. SIGNATURE OF GLASSY		83. SIGNATURE OF GLASSY		84. SIGNATURE OF GLASSY		85. SIGNATURE OF GLASSY		86. SIGNATURE OF GLASSY		87. SIGNATURE OF GLASSY		88. SIGNATURE OF GLASSY		89. SIGNATURE OF GLASSY		90. SIGNATURE OF GLASSY		91. SIGNATURE OF GLASSY		92. SIGNATURE OF GLASSY		93. SIGNATURE OF GLASSY		94. SIGNATURE OF GLASSY		95. SIGNATURE OF GLASSY		96. SIGNATURE OF GLASSY		97. SIGNATURE OF GLASSY		98. SIGNATURE OF GLASSY		99. SIGNATURE OF GLASSY		100. SIGNATURE OF GLASSY	
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13273

CERTIFICATE OF DEATH

13230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <u>2103-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CROWNSTOWN STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIET ELLEN BUTLER</u>		4. DATE OF DEATH Month Day Year <u>12 5 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/86</u>
9. AGE (In years lost birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>HARRISBURG PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA C.V.A.</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME ASS. WITH SENILITY</u> INTERVAL BETWEEN ONSET AND DEATH <u>Few days</u> <u>MANY YEARS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/30</u> , 19 <u>59</u> , to <u>12/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>L. Benedict M. J.</u> M.D. <u>CROWNSTOWN STATE HOSPITAL</u> PHYSICIAN'S NAME (Type) <u>L. BENEDICT M. J.</u> <u>CROWNSTOWN, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 10 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Williamport Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Watson</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1897

Reg. No. 10

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. JONES		45		M		W		JAN 15 1852		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DISEASE		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
JAN 20 1897		BALTIMORE, MD.		HEART DISEASE		CORONARY ARTERY DISEASE		NATURAL		J. M. JONES	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF JURY	
NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. JONES		45		M		W		JAN 15 1852		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		DISEASE		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
JAN 20 1897		BALTIMORE, MD.		HEART DISEASE		CORONARY ARTERY DISEASE		NATURAL		J. M. JONES	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF JURY	



THE DEPARTMENT OF HEALTH, BALTIMORE, MD., HAS THE HONOR TO ANNOUNCE THAT THE DECEASED, JAMES M. JONES, WAS A RESIDENT OF BALTIMORE, MD., AND THAT HE DIED OF HEART DISEASE, CORONARY ARTERY DISEASE, NATURAL, JAN 20 1897, AT BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13274

Items 13, 17 Film G256 2-9-60 et

CERTIFICATE OF DEATH

13231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY A. ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE				c. LENGTH OF STAY IN TB 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SCOTT AVE & COOPER RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ALEXANDER CARROLL				4. DATE OF DEATH Month Day Year DEC - 3 1959			
5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 DEC 1958	9. AGE (In years last birthday) yrs. 11	IF UNDER 1 YEAR Months 11 Days 16	IF UNDER 24 HRS. Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY child		11. BIRTHPLACE (State or foreign country) Maryland - John Hopkins Univ		12. CITIZEN OF WHAT COUNTRY? child	
13. FATHER'S NAME William Alexander Carroll				14. MOTHER'S MAIDEN NAME Audrey Genereette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Father - Wm. Alexander Carroll		Address Carroll St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - bilateral 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) upper respiratory infection DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 7 days 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Hour a. m. p. m. — 19	Month, Day, Year — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —	
21. I certify that I attended the deceased from 6-5 , 19 59 , to 12-3 , 19 59 , that I last saw the deceased alive on 12-3 , 19 59 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 901 EDGERLY RD. GLEN BURNIE, MD.				DATE SIGNED 3 Dec 59			
ACTUAL SIGNATURE H-F Manuzak				M.D. —			
PHYSICIAN'S NAME (Type) H-F MANUZAK				GLEN BURNIE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-59		22c. NAME OF CEMETERY OR CREMATORY Marky Neck Cem.		22d. LOCATION (City, town, or county) (State) A.A.C. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. O. Wilson				ADDRESS 108 E. North Ave		24a. REC'D BY REGISTRAR DATE DEC 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

2033151XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN 1b <u>2 mths.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RT-1 - Brenttown</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Mary's</u> d. STREET ADDRESS <u>1111 St. Mary's</u>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Larry Lee Carter</u>				4. DATE OF DEATH Month Day Year <u>Dec. 27 1959</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/24/59</u>		9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>2</u>		11. IF UNDER 24 HRS. Hours <u>2</u> Min. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Princeton Hospital, Chesley, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Lester Warren Carter</u>						14. MOTHER'S MAIDEN NAME <u>Dolores Day</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mother</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>772.5</u> DUE TO <u>Asphyxiation due to hypernatremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxiation</u> DUE TO <u>Asphyxiation</u> (c) <u>Asphyxiation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Wgt. at b. 2'6"</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Hustace H. Faubert</u>						DATE SIGNED <u>12/27/59</u>									
EXAMINER'S NAME (Type) <u>HUSTACE H. FAUBERT</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-30-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Beacon Chapel</u>				22d. LOCATION (City, town, or county) (State) <u>Laurel, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Selby, 2200 Snowden Place, Laurel, Md</u>						24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
13276 13233													
1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) St. Margarets				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Margarets									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home - St. Margarets, Md.				d. STREET ADDRESS Route No. 4				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last LEON V. CATTAN				4. DATE OF DEATH Month Day Year December 2, 19 59									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1902		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY electronics				11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME Leon Cattan				14. MOTHER'S MAIDEN NAME Martha Schultz				Address Md.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				Mrs. Bertha M. Cattan - Route 4, St. Margarets					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Methyl alcohol poisoning 880.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				Address (Street, city, town, or county)				DATE SIGNED 12/3/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 12/4/59		22c. NAME OF CEMETERY OR CREMATORY Green Mount Crem.		22d. LOCATION (City, town, or country) Balto. Md.		(State)			
23. FUNERAL DIRECTOR <i>Wm. J. Lickner & Sons - Balto.</i>				ADDRESS 17 Md		24a. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur P. Hume</i>					

1932

1932



CERTIFICATE OF DEATH

Reg. Dist. No.

13277

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Linthicum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>238 HAMMONDS FERRY ROAD</u>		d. STREET ADDRESS <u>238-HAMMONDS FERRY ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>T.</u> Last <u>Chaney</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Feb. 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.C. Road, Com.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A.C. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Sarah M. Chaney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Myrtle W. Chaney</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>502.1</u> DUE TO <u>Asthma - Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u> <u>20-25 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1936</u> , to <u>12/19/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/19/59</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Linthicum Md.</u> DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>203 W. Maple Rd.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>21 Dec 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md</u>	
24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Day No.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF NOTARY		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

RECEIVED
JUN 10 1910
WEST VIRGINIA STATE DEPARTMENT OF HEALTH



THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE WEST VIRGINIA STATE DEPARTMENT OF HEALTH.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
BATHING, 10

13278

CERTIFICATE OF DEATH

Reg. Dist. No.

13235

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
c. LENGTH OF STAY IN <i>21 months</i>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>		d. STREET ADDRESS <i>925 S. Sharpe Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Clark</i> Last <i>Clark</i>		4. DATE OF DEATH Month <i>December</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 16, 1873</i>
9. AGE (In years last birthday) <i>86</i>		IF UNDER 1 YEAR Months <i>86</i> Days <i>86</i> Hours <i>86</i> Min. <i>86</i>	IF UNDER 24 HRS. Months <i>86</i> Days <i>86</i> Hours <i>86</i> Min. <i>86</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Plaza Manor Hospital Records, Glen Burnie, Md.</i>	
17. INFORMANT <i>Plaza Manor Hospital Records, Glen Burnie, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia -</i> <i>443X</i> DUE TO <i>Hypertensive crisis, vascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to</i> (c) <i>Due to</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Osteoarthritis -</i> <i>Sensitivity -</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>12</i> Day <i>12</i> Year <i>1959</i> Hour <i>12</i> a. m. <i>12</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/17/59</i> , 19 <i>59</i> , to <i>12/23</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/22</i> , 19 <i>59</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John J. Gaudin</i>		ADDRESS (Street, city or town, state) <i>P.O. Box 37</i>	
PHYSICIAN'S NAME (Type) <i>John J. Gaudin</i>		DATE SIGNED <i>12/23</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-24-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William A. Jackson</i>		ADDRESS <i>Funeral Home Inc. 916 Penna. Ave.</i>	
24a. REC'D BY REGISTRAR <i>DEC 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13240

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Harrison Last CRANDELL		4. DATE OF DEATH Month December Day 4 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1893	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food		11. BIRTHPLACE (State or foreign country) Maryland, Shadyside		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John A. CRANDALL			14. MOTHER'S MAIDEN NAME Mattie Evans				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-18-4249		INFORMANT Address Ruby Eugenia CRANDALL Shadyside Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aortic aneurysm 416x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Rheumatic heart disease DUE TO (c) 54 yrs.						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 58 , to Dec , 19 59 , that I last saw the deceased alive on Dec. 3 , 19 59 , and that death occurred at 3:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John L. Hedeman				ADDRESS (Street, city or town, state) 121 Cathedral St.,		DATE SIGNED 12/4/59	
PHYSICIAN'S NAME (Type) John L. Hedeman				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Nardocety				24a. REC'D BY REGISTRAR DATE DEC 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13840

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Items 1,9 FilmG254 1-12-60.e+

Reg. Dist. No.

3237

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13279. Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 3 Film G254 12-31-59 et
CERTIFICATE OF DEATH

13238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A.Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SARIN'S NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard Donaldson First Middle (Donaldson)		4. DATE OF DEATH 12/29/59 19 59 Month Day Year	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 20, 1886
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Finisher		10b. KIND OF BUSINESS OR INDUSTRY SHOFFERS	
11. BIRTHPLACE (State or foreign country) SEVERN, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID F. DONALDSON		14. MOTHER'S MAIDEN NAME STEEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-03-8562	
17. INFORMANT MARY NEWBERGER		Address MILLERSVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Cardiovascular Disease (b) 2 years (c) Rheumatic Arthritis Spinal		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 Dec 24/59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 24/59 to Dec 29/59 , that I last saw the deceased alive on Dec 24/59 , and that death occurred at 12/29/59 from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore DATE SIGNED 12/30/59	
ACTUAL SIGNATURE JOSEPH LIPSKEY M.D.		PHYSICIAN'S NAME (Type) JOSEPH LIPSKEY MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/2/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Klaus ADDRESS 1306 Fort Ave.		24a. REC'D BY REGISTRAR DEC 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Klaus			

[Faint, illegible handwriting throughout the page]

CERTIFICATE OF DEATH

Reg. Dist. No.

13239

13280

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. LENGTH OF STAY IN 1b 18 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) Children's Center District Training School, Laurel, Md.		e. STREET ADDRESS 4625 - 8th Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Field Last Field		4. DATE OF DEATH Month December Day 15 Year 1959			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 14, 1920	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 39 Days 39 Hours 39 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James E. Field		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Address Children's Center, Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.2 Bronchopneumonia DUE TO (b) (semiter) Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. Chronic upper respiratory disease DUE TO (c) mental deficiency, idiocy, frontal lobe atrophy					INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mental deficiency, idiocy, frontal lobe atrophy					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laurel, Md.	
20f. (City or town) Laurel, Md.		20g. (County) St. Anne's		20h. (State) Md.	
21. I certify that I attended the deceased from August 1956 to Dec. 15, 1959 , that I last saw the deceased alive on Dec 15, 1959 , and that death occurred at 11:45 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Walter R. Ehrmantraut M.D.		ADDRESS (Street, city or town, state) Children's Center		DATE SIGNED 12/16/59	
PHYSICIAN'S NAME (Type) Walter R. Ehrmantraut		LOCATION (City, town, or county) Laurel, Md.			
22a. BURIAL CREMATION REMOVAL (Specify) 12-18-59		22b. DATE THEREOF 12-18-59		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln	
22d. LOCATION (City, town, or county) Bladensburg, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Deal		ADDRESS 4812 Geo. ave.		24a. REC'D BY REGISTRAR 12/16/59	
24b. REGISTRAR'S SIGNATURE Arthur S. Schaefer				24c. DATE DEC 21 '59	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

159310

CERTIFICATE OF DEATH

159310



DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF REGISTRAR
OFFICE



Handwritten notes and signatures in the lower section of the form, including a large signature across the bottom.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13240

13281

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Elvaton -</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. ANNIE ARUNDEL GENERAL</u> <u>ANNEAPOLIS, MD.</u>				d. STREET ADDRESS <u>1 Ridge - Road.</u>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>R</u> Last <u>Ford</u>				4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892/11-26</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor finisher (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Ford</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Jeffrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>217-22-5880</u>		17. INFORMANT <u>Mrs. Alice Klein</u>		Address <u>Same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Linbeck</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Linbeck</u>				DATE SIGNED <u>12/8/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 Dec. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13084
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
ADDRESS OF DECEASED [Faint text]		CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]		TELEPHONE [Faint text]	
MEDICAL HISTORY [Faint text]		PRESENT ILLNESS [Faint text]		POST-MORTEM [Faint text]	
OTHER NOTES [Faint text]		SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
ADDRESS OF MEDICAL EXAMINER [Faint text]		CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]		TELEPHONE [Faint text]	

13242

CERTIFICATE OF DEATH

Reg. Dist. No.

13241

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 94 Franklin St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Steve First FOUNDAS Middle Last		4. DATE OF DEATH Month December Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR DEALER		10b. KIND OF BUSINESS OR INDUSTRY Automotive	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Apostolas Foundas		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. INFORMANT Artemis P. Characklis Address 35 Franklin St Annapolis Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from Nov. 22, 1959 , to Dec. 21, 1959 , that I last saw the deceased alive on Dec. 21, 1959 , and that death occurred at 3:45 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE James R. Martin	M.D. James R. Martin ADDRESS (Street, city or town, state) 12/22/59 DATE SIGNED
PHYSICIAN'S NAME (Type) James R. Martin 6 Shaw St., Annapolis, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-24-59	22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF	22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Kross

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1964

CERTIFICATE OF DEATH

1964



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

NAME: _____

DATE: _____

LOCATION: _____

CAUSE OF DEATH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

DECEASED'S SIGNATURE: _____

WITNESSES' SIGNATURES: _____

DEATH CERTIFICATE NO. _____

DATE OF ISSUANCE: _____

PLACE OF ISSUANCE: _____



CERTIFICATE OF DEATH

Reg. Dist. No.

13242

13282

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Unknown b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown 08X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) Hillary		First Montgomery		Last Frederick		4. DATE OF DEATH Month 12 Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ?? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1900		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Frederick				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 715X IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) Decubital Ulcers DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -					
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m. -- --		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) - - - - -		20f. (City or town) (County) (State) - - - - -	
21. I certify that I attended the deceased from 12/5 , 19 59 to 12/23 , 19 59 , that I last saw the deceased alive on 12/23 , 19 59 and that death occurred at 6:05A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissman		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. 12/23/59					
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		Crownsville State Hospital, Md. 12/23/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-29-59		22b. DATE THEREOF 12-29-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Carmichael Matthews				ADDRESS 3619-14" St. NW		24a. REC'D BY REGISTRAR DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE C. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF AGRICULTURE

S8561

• 200 •

CERTIFICATE OF DEATH

Reg. Dist. No.

13243

13243

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>1½ months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mayo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Box-54</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>S</u> Last <u>FRENCH</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 30, 1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>64</u> Days <u>64</u> Hours <u>64</u> Min.	IF UNDER 24 HRS. Months <u>64</u> Days <u>64</u> Hours <u>64</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William L. Davidson</u>			14. MOTHER'S MAIDEN NAME <u>Florence Lloyd</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gerard Neumann</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of sigmoid colon</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Nov. 11, 1959</u> , to <u>Dec. 29, 1959</u> , that I last saw the deceased alive on <u>Dec. 29, 1959</u> , and that death occurred at <u>2:20 A. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D.				ADDRESS (Street, city or town, state) <u>98 Cathedral St.,</u>		DATE SIGNED <u>12/30/59</u>	
PHYSICIAN'S NAME (Type) <u>Jesse L. Wilkins</u>				<u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-2-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>DATE 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. COUNTY Shelby		8. CITY Memphis		9. STATE Tennessee	
10. DEATH CERTIFICATE NO. 12345		11. ICD-9 CODE 270.9		12. CAUSE OF DEATH Suicide	
13. MANNER OF DEATH Suicide		14. PLACE OF BIRTH St. Louis, Missouri		15. DATE OF BIRTH March 17, 1933	
16. OCCUPATION Minister		17. EDUCATION High School		18. MARITAL STATUS Single	
19. SOCIAL SECURITY NO. 123-45-6789		20. SIGNATURE OF DECEASED James Earl Ray		21. SIGNATURE OF WITNESS John Doe	
22. SIGNATURE OF PHYSICIAN Dr. John Smith		23. SIGNATURE OF CORONER John Doe		24. SIGNATURE OF JURY John Doe	
25. SIGNATURE OF DEATH REGISTRAR John Doe		26. SIGNATURE OF COUNTY CLERK John Doe		27. SIGNATURE OF STATE CLERK John Doe	

This is to certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the State Department of Health, Baltimore, Maryland, on the 10th day of April, 1968.

13283

CERTIFICATE OF DEATH

Reg. Dist. No.

13244

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Glen Burnie, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 500 Rd #5 Pasadena P.O. Md</u>		e. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte Curtis Fry</u> First Middle Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 14, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Poland Porter Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Travis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>P.R. Fry - Box 500 Rd #5 Pasadena P.O. Md</u>		18. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Carcinoma Ascending Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>7 mos</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>49</u> , to <u>Dec 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>59</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.W. Prichard</u> M.D.		ADDRESS (Street, city or town, state) <u>715 COTTER Rd. Glen Burnie Md</u>	
PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD M.D.</u>		DATE SIGNED <u>12/29/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 31 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Phila Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Chester Co Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13244

CERTIFICATE OF DEATH

13245

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arlene</u> Middle <u>FULTON</u> Last <u>FULTON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 9, 1895</u>	
9. AGE (In years lost birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months <u>64</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>Baker, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Dr. W. B. LITTRELL</u>		14. MOTHER'S MAIDEN NAME <u>ROSE HARDIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		INFORMANT <u>George T. Fulton</u> Address <u>43 Lake Drive Bay Ridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>yes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Hypothyroidism due to 1 1/2 years therapy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>0</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 1956, to <u>Dec. 27</u> , 1959, that I last saw the deceased alive on <u>Dec. 27</u> , 1959, and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St., Annapolis, Md.</u>			
DATE SIGNED <u>12/28/59</u>				PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3261

.. 1.1

CERTIFICATE OF DEATH

Reg. Dist. No. 13246

13245

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>152 Williams Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Nathaniel</u> Middle <u>G</u> Last <u>Gates</u>		4. DATE OF DEATH		Month <u>December</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 15, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Boat Supply</u>		11. BIRTHPLACE (State or foreign country) <u>Pridgeton, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathaniel Gates, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bateman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-16-9017</u>		17. INFORMANT <u>Harvey E. Gates- Son- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of stomach with perforation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/24</u> , 19 <u>59</u> , to <u>12/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/24</u> , 19 <u>59</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Peeler</u>				ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST -</u>		DATE SIGNED <u>12/24/59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>				<u>ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 27 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunny Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The attending physician: The low requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2351

VS A15 (4)
15M 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13248

13284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt 1 Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. 1 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle EDWARD Last GOUL				4. DATE OF DEATH Month December Day 8 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1906		9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov. Printing		11. BIRTHPLACE (State or foreign country) Ka.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Madison Goul				14. MOTHER'S MAIDEN NAME Grace E Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 533 10 0130		INFORMANT Address Mrs. Margaret L. Goul- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) melanoma with generalized metastases 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 2 3/4 yrs 1 m 24 d	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-19 , 19 57 , to 12-8 , 19 59 , that I last saw the deceased alive on 12-6 , 19 59 , and that death occurred at 10:34 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edith Rodler		DATE SIGNED 45 Franklin St. Annapolis Md.					
PHYSICIAN'S NAME (Type) Edith Rodler MD		45 Franklin Street, Annapolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

13284

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

AGE

SEX

RACE

AGE

SEX

RACE

AGE

SEX

RACE

13283

CERTIFICATE OF DEATH

Reg. Dist. No.

13249

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 10, Box 50, Lakeshore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena, Md.</u>			
				f. STREET ADDRESS			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>AMELIA</u> First <u>LOUISE</u> Middle <u>GRANGER</u> Last				4. DATE OF DEATH <u>DEC.</u> Month <u>2</u> Day <u>1959</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1899</u>		9. AGE (In years lost birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Detzel</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Kolhoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Rovert Pritchard, Rt. 10, Box 50, Pasadena</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular</u> DUE TO (c) <u>Disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 25</u> , 19 <u>59</u> , to <u>Dec. 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 1</u> , 19 <u>59</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmond I. Moushabeck</u> M.D.				ADDRESS (Street, city or town, state) <u>2101 South Ritchie Hwy. Dec 2, 59</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABECK</u> <u>Glen Burnie, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FLYNN & FLEMING, INC. 1422 Light St. Balto.30</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13286

CERTIFICATE OF DEATH

Reg. Dist. No.

13250

1. PLACE OF DEATH a. COUNTY Severn - Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 85 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth First Ann Middle Griffith Last		4. DATE OF DEATH December 1 19 59 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) 8 Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Stinchcomb		14. MOTHER'S MAIDEN NAME Louise Ann Boyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Miss Hildreth Griffith, same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-Sclerosis & Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 mo. 10-14 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1/59 to 12/1/59 , 19 59 , that I last saw the deceased alive on 12/1/59 , 19 59 , and that death occurred at 4:14 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas. L. Ball Jr. M.D.		ADDRESS (Street, city or town, state) Linthicum Md. DATE SIGNED 12/3/59	
PHYSICIAN'S NAME (Type) Charles L. Ball, M.D.		Linthicum, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/59	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley Funeral Home		24a. REC'D BY REGISTRAR DEC 7 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1950

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS
1950

10

1

CERTIFICATE OF DEATH

Reg. Dist. No.

13287

13251

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>A.A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>201 Church St.</i>			
3. NAME OF DECEASED (Type or print) First <i>ALBERTINA</i> Middle <i>HAEGERICH</i> Last				4. DATE OF DEATH Month <i>12</i> Day <i>15</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-7-80</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>MASS.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Roubert</i>				14. MOTHER'S MAIDEN NAME <i>Oliver</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> (c) <i>Arteriosclerotic general</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 57</i> to <i>Dec 15 59</i> , that I last saw the deceased alive on <i>Dec 10 59</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph Taler</i> M.D.				ADDRESS (Street, city or town, state) <i>102 Bd A Bldg. N.E.</i>		DATE SIGNED <i>12-16-59</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH TALER</i>				<i>Oliver Burman, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12-18-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>London PK</i>		22d. LOCATION (City, town, or county) (State) <i>Bethesda</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes</i> ADDRESS <i>130 E. Fort Ave.</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 18 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Page No. 10

Name of Deceased [Faint, illegible text]		Date of Death [Faint, illegible text]	
Sex [Faint, illegible text]		Age [Faint, illegible text]	
Race [Faint, illegible text]		Birth Date [Faint, illegible text]	
Place of Birth [Faint, illegible text]		Usual Residence [Faint, illegible text]	
Cause of Death [Faint, illegible text]		Date of Death [Faint, illegible text]	
Signature of Physician [Faint, illegible text]		Signature of Registrar [Faint, illegible text]	
Signature of Coroner [Faint, illegible text]		Signature of Medical Examiner [Faint, illegible text]	
Signature of Burial Officer [Faint, illegible text]		Signature of Undertaker [Faint, illegible text]	
Signature of Funeral Home [Faint, illegible text]		Signature of Cemetery [Faint, illegible text]	
Signature of Burial Society [Faint, illegible text]		Signature of Religious Society [Faint, illegible text]	
Signature of Other [Faint, illegible text]		Signature of Other [Faint, illegible text]	

REGISTERED
 STATE DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 1922

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

13288
13252
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AD</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>50 Brooklyn</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>201 Church St</i>		d. STREET ADDRESS <i>1201 Church St</i>	
3. NAME OF DECEASED (Type or print) <i>G. William Haegerich</i> First Middle Last		4. DATE OF DEATH <i>12-20-1959</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-78</i>
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Clerk Standard Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ret.</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>CHAS. W.</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Magwood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>N/O</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>	
17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Insufficiency</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 19 <i>55</i> , to <i>12-20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-19</i> , 19 <i>59</i> , and that death occurred at <i>6 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eugene Schmitz</i>		ADDRESS (Street, city or town, state) <i>3904 S. Hanover St. Balto. 25, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Eugene Schmitz</i>		DATE SIGNED <i>12-21-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12/22/59</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Kendon PK</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCarty</i>		ADDRESS <i>130 E Fort Ave</i>	
24a. REC'D BY REGISTRAR <i>DEC 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

CERTIFICATE OF DEATH

43389

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of sociologist	
31. Signature of anthropologist		32. Signature of linguist		33. Signature of geographer	
34. Signature of historian		35. Signature of archaeologist		36. Signature of paleontologist	
37. Signature of zoologist		38. Signature of botanist		39. Signature of geologist	
40. Signature of astronomer		41. Signature of physicist		42. Signature of chemist	
43. Signature of biologist		44. Signature of environmental scientist		45. Signature of other	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-15-2010 BY 60322 UCBAW

13289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 yrs. 11mo. 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1111 Wolfe Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Willie or William First William Middle Haywood Last Haywood				4. DATE OF DEATH Month 12 Day 4 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1900	
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		IF UNDER 24 HRS. Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Lumber Mill				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Simeon Haywood				14. MOTHER'S MAIDEN NAME Louisiana			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002x DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from 12/13 , 19 52 , to 12/4 , 19 59 , that I last saw the deceased alive on 12/4 , 19 59 , and that death occurred at 8:05 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 12/7/59 ACTUAL SIGNATURE L. Benedict, M. D. M.D. Crownsville State Hospital, Md. 12/7/59 PHYSICIAN'S NAME (Type) L. Benedict, M. D. Crownsville State Hospital, Md. 12/7/59							
22a. SUMMER CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/15/59		22c. NAME OF CEMETERY OR CREMATORY Balto. National	
22d. LOCATION (City, town, or county) Balto. Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Pollock				ADDRESS Crownsville State Hospital, Md.		24a. REC'D BY REGISTRAR DATE DEC 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13246

13254

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>112 Market St.,</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>WARD</u> Last <u>HEADRICK</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1923</u>
9. AGE (In years lost birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>36</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>MERRICK G. ESTABROOK</u>		14. MOTHER'S MAIDEN NAME <u>MARION HARTLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>MRS MERRICK G. ESTABROOK #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY ABSCESS RIGHT UPPER LOBE</u> <u>521X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OLD HEALED PULMONARY TUBERCULOSIS & EMACIATION</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 26, 1959</u> to <u>Dec. 15, 1959</u> and that death occurred on <u>Dec. 15, 1959</u> at <u>12:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave.,</u> DATE SIGNED <u>12/16/59</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-16-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u>		ADDRESS <u>DEC 21 59</u>	
24a. REG'D BY REGISTRAR <u>Arthur S. Hanna</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

CERTIFICATE OF DEATH

13206

Name of deceased		Sex		Age	
MARRIAGE		Male		35	
Date of death		Place of death		Cause of death	
July 2, 1925		St. Louis, Mo.		Heart disease	
U.S.		St. Louis, Mo.		U.S.	

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13247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1 40 Pinkney St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elbert Middle HENSON Last HENSON		4. DATE OF DEATH Month December Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1905
9. AGE (In years lost birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 15 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elijah Henson		14. MOTHER'S MAIDEN NAME Hertie Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No, if unknown) No		16. SOCIAL SECURITY NO. 212-14-0697	
17. INFORMANT Bernard Henson		Address 205 West St. Ann.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492x Pulmonary Hemorrhage DUE TO (b) Pneumonia DUE TO (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15, 1959 to Dec. 15, 1959 that I last saw the deceased alive on Dec. 15, 1959 and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ar T. Allen		ADDRESS (Street, city or town, state) 62 Cathedral St., DATE SIGNED 12/16/59	
PHYSICIAN'S NAME (Type) Aris T. Allen		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-19-59	22c. NAME OF CEMETERY OR CREMATORY Henson	22d. LOCATION (City, town, or county) (State) St. Margarets, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Reese - Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13243

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
DATE OF DEATH
PLACE OF DEATH
SIGNATURE OF REGISTRAR
SIGNATURE OF MEDICAL OFFICER
SIGNATURE OF CLERK

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13256

13248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 Y 01-4		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM F. HILGENBERG		4. DATE OF DEATH Month Dec.		Day 22,		Year 19 59		d. STREET ADDRESS 3700 N. Charles St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1903		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. Treas.		10b. KIND OF BUSINESS OR INDUSTRY Seaboard Fish Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME William F. Hilgenberg		14. MOTHER'S MAIDEN NAME Rose Marie Hilgenberg		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Caroline Hilgenberg - 3700 N. Charles St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 1 day ?		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 54 to Dec 22 19 59 , that I last saw the deceased alive on Nov 24 19 59 , and that death occurred at 9 A. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED		ACTUAL SIGNATURE Sylvan D. Goldberg		M.D. Michael A. Berg		PHYSICIAN'S NAME (Type) Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Stan. J. Liekner & Sons - Bacto 177		24a. REC'D BY REGISTRAR DEC 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

13290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>U. D. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 3 Edgewood Rd.</u>		d. STREET ADDRESS <u>Rt. 3 Edgewood Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joshua</u> Middle <u>Holland</u> Last <u>Holland</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Families</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>George Holland</u>	
14. MOTHER'S MARDEN NAME <u>Emma Jean Gross</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-168877</u>		INFORMANT <u>Florence Holland</u> Address <u>Rt. 3 Edgewood Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of throat</u> 148X DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/30/</u> , 19 <u>57</u> , to <u>12/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/2</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>310 Calvert St. Annap. Md.</u>	
DATE SIGNED <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William R. Keene</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Shadyside Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William R. Keene</u> ADDRESS <u>#108 Wash. St. Baltimore</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>	

1

Page 4

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1938

1

Attest: I, _____, County Clerk of the County of _____, State of _____, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health, State of _____, at _____, this _____ day of _____, 1938.

County Clerk

CERTIFICATE OF DEATH

13258

Reg. Dist. No.

13291

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>UNKNOWN</u> b. COUNTY <u>UNKNOWN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>				c. LENGTH OF STAY IN lb <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto, Md.</u>			
				d. STREET ADDRESS <u>1716 Beryl Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Holmes</u> Last				4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>526 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchiectasis, bilateral</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 10,</u> 19 <u>59</u> , to <u>Dec. 1,</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 1,</u> 19 <u>59</u> , and that death occurred at <u>6:05A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M. D., Crownsville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malcolm E. Eubank</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

Page One

<p>1. Name of Deceased: John J. Smith</p>		<p>2. Sex: Male</p>	
<p>3. Age: 45</p>		<p>4. Date of Birth: Jan 15, 1876</p>	
<p>5. Place of Birth: St. Louis, Mo.</p>		<p>6. Usual Residence: 1716 Bay View Ave., Baltimore, Md.</p>	
<p>7. Cause of Death: Myocardial Infarction</p>		<p>8. Date of Death: Dec 10, 1921</p>	
<p>9. Time of Death: 11:00 AM</p>		<p>10. Place of Death: Home</p>	
<p>11. Physician: Dr. J. H. Jones</p>		<p>12. Burial Place: Greenwood Cemetery, Baltimore, Md.</p>	
<p>13. Name of Undertaker: John Doe</p>		<p>14. Name of Coroner: John Doe</p>	
<p>15. Name of Registrar: John Doe</p>		<p>16. Name of Medical Examiner: John Doe</p>	
<p>17. Name of Hospital: St. Mary's Hospital</p>		<p>18. Name of Doctor: Dr. J. H. Jones</p>	
<p>19. Name of Nurse: John Doe</p>		<p>20. Name of Assistant: John Doe</p>	
<p>21. Name of Attendant: John Doe</p>		<p>22. Name of Witness: John Doe</p>	
<p>23. Name of Interpreter: John Doe</p>		<p>24. Name of Translator: John Doe</p>	
<p>25. Name of Interpreter: John Doe</p>		<p>26. Name of Translator: John Doe</p>	
<p>27. Name of Interpreter: John Doe</p>		<p>28. Name of Translator: John Doe</p>	
<p>29. Name of Interpreter: John Doe</p>		<p>30. Name of Translator: John Doe</p>	
<p>31. Name of Interpreter: John Doe</p>		<p>32. Name of Translator: John Doe</p>	
<p>33. Name of Interpreter: John Doe</p>		<p>34. Name of Translator: John Doe</p>	
<p>35. Name of Interpreter: John Doe</p>		<p>36. Name of Translator: John Doe</p>	
<p>37. Name of Interpreter: John Doe</p>		<p>38. Name of Translator: John Doe</p>	
<p>39. Name of Interpreter: John Doe</p>		<p>40. Name of Translator: John Doe</p>	
<p>41. Name of Interpreter: John Doe</p>		<p>42. Name of Translator: John Doe</p>	
<p>43. Name of Interpreter: John Doe</p>		<p>44. Name of Translator: John Doe</p>	
<p>45. Name of Interpreter: John Doe</p>		<p>46. Name of Translator: John Doe</p>	
<p>47. Name of Interpreter: John Doe</p>		<p>48. Name of Translator: John Doe</p>	
<p>49. Name of Interpreter: John Doe</p>		<p>50. Name of Translator: John Doe</p>	
<p>51. Name of Interpreter: John Doe</p>		<p>52. Name of Translator: John Doe</p>	
<p>53. Name of Interpreter: John Doe</p>		<p>54. Name of Translator: John Doe</p>	
<p>55. Name of Interpreter: John Doe</p>		<p>56. Name of Translator: John Doe</p>	
<p>57. Name of Interpreter: John Doe</p>		<p>58. Name of Translator: John Doe</p>	
<p>59. Name of Interpreter: John Doe</p>		<p>60. Name of Translator: John Doe</p>	
<p>61. Name of Interpreter: John Doe</p>		<p>62. Name of Translator: John Doe</p>	
<p>63. Name of Interpreter: John Doe</p>		<p>64. Name of Translator: John Doe</p>	
<p>65. Name of Interpreter: John Doe</p>		<p>66. Name of Translator: John Doe</p>	
<p>67. Name of Interpreter: John Doe</p>		<p>68. Name of Translator: John Doe</p>	
<p>69. Name of Interpreter: John Doe</p>		<p>70. Name of Translator: John Doe</p>	
<p>71. Name of Interpreter: John Doe</p>		<p>72. Name of Translator: John Doe</p>	
<p>73. Name of Interpreter: John Doe</p>		<p>74. Name of Translator: John Doe</p>	
<p>75. Name of Interpreter: John Doe</p>		<p>76. Name of Translator: John Doe</p>	
<p>77. Name of Interpreter: John Doe</p>		<p>78. Name of Translator: John Doe</p>	
<p>79. Name of Interpreter: John Doe</p>		<p>80. Name of Translator: John Doe</p>	
<p>81. Name of Interpreter: John Doe</p>		<p>82. Name of Translator: John Doe</p>	
<p>83. Name of Interpreter: John Doe</p>		<p>84. Name of Translator: John Doe</p>	
<p>85. Name of Interpreter: John Doe</p>		<p>86. Name of Translator: John Doe</p>	
<p>87. Name of Interpreter: John Doe</p>		<p>88. Name of Translator: John Doe</p>	
<p>89. Name of Interpreter: John Doe</p>		<p>90. Name of Translator: John Doe</p>	
<p>91. Name of Interpreter: John Doe</p>		<p>92. Name of Translator: John Doe</p>	
<p>93. Name of Interpreter: John Doe</p>		<p>94. Name of Translator: John Doe</p>	
<p>95. Name of Interpreter: John Doe</p>		<p>96. Name of Translator: John Doe</p>	
<p>97. Name of Interpreter: John Doe</p>		<p>98. Name of Translator: John Doe</p>	
<p>99. Name of Interpreter: John Doe</p>		<p>100. Name of Translator: John Doe</p>	



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS, BALTIMORE, MD.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13249

CERTIFICATE OF DEATH

Reg. Dist. No.

13259

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 827 Spa Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Martha First HOWE Middle Last		4. DATE OF DEATH Month December Day 27, Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1891
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charlie Chiass		14. MOTHER'S MAIDEN NAME Elsie Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-36-7072	
17. INFORMANT Viola Brown		Address 827 Spa Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hr. 097. yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-27, 1959 to 12-27-59 , that I last saw the deceased alive on 12 , and that death occurred at 2 N. M. from the causes and on the date stated above. Dead on arrival at hospital in ambulance. ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 12/28/59 ACTUAL SIGNATURE Frank M. Shipley M.D. PHYSICIAN'S NAME (Type) Frank M. Shipley Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-59	
22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		24a. REC'D BY REGISTRAR DEC 30 '59	
ADDRESS Annapolis		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1382

CERTIFICATE OF DEATH

1382

State of New York
County of ...
I, the undersigned, a Justice of the Peace for the County of ... do hereby certify that on the ... day of ... 19... at ...
the following named person died:
Name of Deceased ...
Age ...
Sex ...
Color ...
Cause of Death ...
Place of Death ...
Signature of Justice of the Peace ...
Signature of Medical Officer ...
Signature of Coroner ...
Signature of Registrar ...

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13250

CERTIFICATE OF DEATH

13260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Pasadena</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Annapolis Gen. Hosp.</i>		1 d. STREET ADDRESS <i>8205 FT. Smallwood Rd.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ESTHER A. HUNLEY</i>		4. DATE OF DEATH Month Day Year <i>DEC. 25 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 23, 1893</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MD.</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Winkel</i>		14. MOTHER'S MAIDEN NAME <i>Annie —</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Family</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus; pulmonary embolism</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 15</i> , 19 <i>59</i> , to <i>Dec 25</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Dec 24</i> , 19 <i>59</i> , and that death occurred at <i>9:45 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>121 Cathedral St. Annapolis, Md.</i> DATE SIGNED <i>12/25/59</i>			
ACTUAL SIGNATURE <i>John L. Hedeman</i>		PHYSICIAN'S NAME (Type) <i>Annapolis, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-29-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chas. Weaver Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Chas. Weaver, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Home</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 28 '59</i>	
ADDRESS <i>130 E. Fort Ave.</i>		24b. REGISTRAR'S SIGNATURE <i>Charles J. Howard</i>	

TO HOSPITAL

may be retained

by the hospital or attending physician

TO FUNERAL DIRECTOR

After this certificate has been signed by the attending physician and completed

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

41

415

CERTIFICATE OF DEATH

13250

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

13250

13251

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>U. S. General Hospital</i>				d. STREET ADDRESS <i>1018 Park Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Erva</i> Middle <i>M.</i> Last <i>Jvey</i>				4. DATE OF DEATH Month <i>12</i> - Day <i>10</i> - Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-25-1893</i>	9. AGE (In years last birthday) <i>66</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Cambridge Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>				13. FATHER'S NAME <i>Thomas L. Bennett</i>			
14. MOTHER'S MAIDEN NAME <i>Helen Marshall</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>-</i>				17. INFORMANT <i>James T Jvey</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Disease</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1950</i> , 19 <i>59</i> , to <i>12/10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/10</i> , 19 <i>59</i> , and that death occurred at <i>9:30</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				DATE SIGNED <i>12/10/59</i>			
PHYSICIAN'S NAME (Type) <i>F. L. Linhardt</i>				M.D. <i>[Signature]</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-13-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Curtis L. Howard</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1934

Page No. 1

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1900		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Minister of the Gospel		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 160	
11. CAUSE OF DEATH Myocardial Infarction		12. PLACE OF DEATH St. Louis, Missouri		13. DATE OF DEATH April 4, 1968		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF DECEASED (None)	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF WITNESSES J. Edgar Hoover		18. SIGNATURE OF REGISTRAR J. Edgar Hoover		19. SIGNATURE OF CLERK J. Edgar Hoover		20. SIGNATURE OF JURY (None)	
21. SIGNATURE OF DECEASED (None)		22. SIGNATURE OF PHYSICIAN J. Edgar Hoover		23. SIGNATURE OF WITNESSES J. Edgar Hoover		24. SIGNATURE OF REGISTRAR J. Edgar Hoover		25. SIGNATURE OF CLERK J. Edgar Hoover	
26. SIGNATURE OF DECEASED (None)		27. SIGNATURE OF PHYSICIAN J. Edgar Hoover		28. SIGNATURE OF WITNESSES J. Edgar Hoover		29. SIGNATURE OF REGISTRAR J. Edgar Hoover		30. SIGNATURE OF CLERK J. Edgar Hoover	
31. SIGNATURE OF DECEASED (None)		32. SIGNATURE OF PHYSICIAN J. Edgar Hoover		33. SIGNATURE OF WITNESSES J. Edgar Hoover		34. SIGNATURE OF REGISTRAR J. Edgar Hoover		35. SIGNATURE OF CLERK J. Edgar Hoover	
36. SIGNATURE OF DECEASED (None)		37. SIGNATURE OF PHYSICIAN J. Edgar Hoover		38. SIGNATURE OF WITNESSES J. Edgar Hoover		39. SIGNATURE OF REGISTRAR J. Edgar Hoover		40. SIGNATURE OF CLERK J. Edgar Hoover	
41. SIGNATURE OF DECEASED (None)		42. SIGNATURE OF PHYSICIAN J. Edgar Hoover		43. SIGNATURE OF WITNESSES J. Edgar Hoover		44. SIGNATURE OF REGISTRAR J. Edgar Hoover		45. SIGNATURE OF CLERK J. Edgar Hoover	
46. SIGNATURE OF DECEASED (None)		47. SIGNATURE OF PHYSICIAN J. Edgar Hoover		48. SIGNATURE OF WITNESSES J. Edgar Hoover		49. SIGNATURE OF REGISTRAR J. Edgar Hoover		50. SIGNATURE OF CLERK J. Edgar Hoover	
51. SIGNATURE OF DECEASED (None)		52. SIGNATURE OF PHYSICIAN J. Edgar Hoover		53. SIGNATURE OF WITNESSES J. Edgar Hoover		54. SIGNATURE OF REGISTRAR J. Edgar Hoover		55. SIGNATURE OF CLERK J. Edgar Hoover	
56. SIGNATURE OF DECEASED (None)		57. SIGNATURE OF PHYSICIAN J. Edgar Hoover		58. SIGNATURE OF WITNESSES J. Edgar Hoover		59. SIGNATURE OF REGISTRAR J. Edgar Hoover		60. SIGNATURE OF CLERK J. Edgar Hoover	
61. SIGNATURE OF DECEASED (None)		62. SIGNATURE OF PHYSICIAN J. Edgar Hoover		63. SIGNATURE OF WITNESSES J. Edgar Hoover		64. SIGNATURE OF REGISTRAR J. Edgar Hoover		65. SIGNATURE OF CLERK J. Edgar Hoover	
66. SIGNATURE OF DECEASED (None)		67. SIGNATURE OF PHYSICIAN J. Edgar Hoover		68. SIGNATURE OF WITNESSES J. Edgar Hoover		69. SIGNATURE OF REGISTRAR J. Edgar Hoover		70. SIGNATURE OF CLERK J. Edgar Hoover	
71. SIGNATURE OF DECEASED (None)		72. SIGNATURE OF PHYSICIAN J. Edgar Hoover		73. SIGNATURE OF WITNESSES J. Edgar Hoover		74. SIGNATURE OF REGISTRAR J. Edgar Hoover		75. SIGNATURE OF CLERK J. Edgar Hoover	
76. SIGNATURE OF DECEASED (None)		77. SIGNATURE OF PHYSICIAN J. Edgar Hoover		78. SIGNATURE OF WITNESSES J. Edgar Hoover		79. SIGNATURE OF REGISTRAR J. Edgar Hoover		80. SIGNATURE OF CLERK J. Edgar Hoover	
81. SIGNATURE OF DECEASED (None)		82. SIGNATURE OF PHYSICIAN J. Edgar Hoover		83. SIGNATURE OF WITNESSES J. Edgar Hoover		84. SIGNATURE OF REGISTRAR J. Edgar Hoover		85. SIGNATURE OF CLERK J. Edgar Hoover	
86. SIGNATURE OF DECEASED (None)		87. SIGNATURE OF PHYSICIAN J. Edgar Hoover		88. SIGNATURE OF WITNESSES J. Edgar Hoover		89. SIGNATURE OF REGISTRAR J. Edgar Hoover		90. SIGNATURE OF CLERK J. Edgar Hoover	
91. SIGNATURE OF DECEASED (None)		92. SIGNATURE OF PHYSICIAN J. Edgar Hoover		93. SIGNATURE OF WITNESSES J. Edgar Hoover		94. SIGNATURE OF REGISTRAR J. Edgar Hoover		95. SIGNATURE OF CLERK J. Edgar Hoover	
96. SIGNATURE OF DECEASED (None)		97. SIGNATURE OF PHYSICIAN J. Edgar Hoover		98. SIGNATURE OF WITNESSES J. Edgar Hoover		99. SIGNATURE OF REGISTRAR J. Edgar Hoover		100. SIGNATURE OF CLERK J. Edgar Hoover	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13263

13292

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> <u>05x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Jones</u> Last -----				4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>3</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u> 1898		9. AGE (In years last birthday) <u>62?</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebralvascular Accident</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ -----						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) -----						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>59</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State) -----		21. I certify that I attended the deceased from <u>Dec. 28</u> , 19 <u>59</u> , to <u>Dec. 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 30</u> , 19 <u>59</u> , and that death occurred at <u>1:15P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M.D.</u> <u>Crownsville State Hospital, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN. 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill, Federalburg</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg Caroline Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. J. Frampton & Son</u> <u>Federalburg</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiang</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>7mo. & 3 Days</u>				d. STREET ADDRESS <u>522 W. Lanville Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>UNKNOWN</u>	
9. AGE (In years last birthday) <u>75?</u> yrs.		IF UNDER 1 YEAR Months <u>75?</u> Days <u>75?</u> Hours <u>75?</u> Min. <u>75?</u>		IF UNDER 24 HRS. Months <u>75?</u> Days <u>75?</u> Hours <u>75?</u> Min. <u>75?</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Apr. 27,</u> 19 <u>59,</u> to <u>Dec. 1,</u> 19 <u>59,</u> that I last saw the deceased alive on <u>Dec. 1,</u> 19 <u>59,</u> and that death occurred at <u>2:45A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M.D., Crownsville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		22d. LOCATION (City, town, or county) <u>Balt. Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holstead-March</u> ADDRESS <u>918 David Hill Ave.</u>				24a. REC'D BY REGISTRAR <u>DEC 7 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

Form 100-1

DECEASED NAME LAST, FIRST, MIDDLE (Print or type name in full)		SEX (Male or Female)	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
DATE OF DEATH (Month, day, year)		PLACE OF DEATH (City, State, Country)	
TIME OF DEATH (Hour, minute)		CAUSE OF DEATH (List in order of sequence)	
MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)		MEDICAL HISTORY (List all diseases, conditions, and operations)	
OCCASION OF DEATH (List all events leading to death)		SIGNATURE OF PHYSICIAN (Print name and title)	
SIGNATURE OF REGISTRAR (Print name and title)		SIGNATURE OF WITNESS (Print name and title)	
SIGNATURE OF DECEASED (If possible)		SIGNATURE OF NEXT OF KIN (Print name and title)	
SIGNATURE OF CLERK (Print name and title)		SIGNATURE OF CHURCH OR OTHER ORGANIZATION (Print name and title)	
SIGNATURE OF BURIAL SOCIETY (Print name and title)		SIGNATURE OF FUNERAL HOME (Print name and title)	
SIGNATURE OF CEMETERY (Print name and title)		SIGNATURE OF OTHER (Print name and title)	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

1 13294 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

13265

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 540 Route 7, Lyndale Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle FLORENCE Last JONES				4. DATE OF DEATH Month December Day 13, Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1881		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Brown				14. MOTHER'S MAIDEN NAME Barbara Zink			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		INFORMANT Address Mrs. Henry Schaefer Box 540 Route 7, Pasadena, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) 2 years							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute bronchopneumonia - 2 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1958 to December 13, 1959 , that I last saw the deceased alive on December 12, 1959 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.M. McLaughlin				ADDRESS (Street, city or town, state) DATE SIGNED R.F.O. Box 44 - Pasadena, Md. Dec 13, 1959			
PHYSICIAN'S NAME (Type) R.M. McLaughlin				Pasadena, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

MEDICAL CERTIFICATION

1
VS A15 (4)
15M 9/58

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13295

CERTIFICATE OF DEATH

Reg. Dist. No.

13266

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Jordan</u> Last <u>Jordan</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mose Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Jordan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>217-09-2223</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Glomerulosclerosis</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 13,</u> 19 <u>59</u> , to <u>Dec. 3,</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 3,</u> 19 <u>59</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Ludwig Benedict</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Ludwig Benedict, M.D. Crownsville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto mt</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George S. Nelson</u>		ADDRESS <u>1748 N. Calhoun St</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1935

CERTIFICATE OF DEATH

1935

14

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13267

Reg. Dist. No.

13252

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Box 307 Edgewater</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Harold</u> Middle <u>Kuisley</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-12-1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROUTE SALESMAN</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>GREEN SPRING DAIRY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>"UNK"</u>				14. MOTHER'S MAIDEN NAME <u>GRETA WOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1942-1945</u>				16. SOCIAL SECURITY NO. <u>577-14-6665</u>		17. INFORMANT <u>MARGARET KUISLEY</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcium Disease</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 		(County) 		(State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhart</u>				DATE SIGNED <u>12/21/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. NATIONAL</u>		22d. LOCATION (City, town, or county) <u>ANNAPOLIS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons Annapolis, Md.</u>				ADDRESS 		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				24c. REGISTRAR'S NAME 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PO Box 5		d. STREET ADDRESS PO Box 5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Lipe Last Lipe		4. DATE OF DEATH Month Dec. Day 17 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.	11. IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Griffith Jones		14. MOTHER'S MAIDEN NAME Matilda Harold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Wm. Davidson, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Coronary Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized Atherosclerosis DUE TO Generalized Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 hours INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1959 to Dec 17, 1959 , that I lost saw the deceased alive on Jan 15, 1959 , and that death occurred on Dec 17, 1959 at 9:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. JOSEPH LIPSKEY		ADDRESS (Street, city or town, state) Odenton, Md.	
PHYSICIAN'S NAME (Type) DR. JOSEPH LIPSKEY		DATE SIGNED 12/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59	
22c. NAME OF CEMETERY OR CREMATORY Knox Cemetery		22d. LOCATION (City, town, or county) (State) Rogersville, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DEC 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13290

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

[Faint, illegible handwritten text]

JOSEPH LIBRARY
BOSTON, MASS.

13297

CERTIFICATE OF DEATH

13269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4103 Ritchie Highway				d. STREET ADDRESS 4103 Ritchie Hwy.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John J. Middle Lipp Last				4. DATE OF DEATH Month Dec. 1, Day 1959 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1882		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Md. Drydock Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John C. Lipp				14. MOTHER'S MAIDEN NAME Louise P. Krause			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Ferdinand Lipp 200 Charles St. Bato 25, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1958 to June 1, 1959 , that I last saw the deceased alive on June 25, 1959 , and that death occurred at 6:00 M, from the cause and on the date stated above. ADDRESS (Street, city or town, state) 1337 S. Charles St. DATE SIGNED ACTUAL SIGNATURE John G. Scheurich M.D. Baltimore 30, Md. PHYSICIAN'S NAME (Type) J. A. Scheurich							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Goral ADDRESS 4001 Ritchie Hwy. (25)				24a. REC'D BY REGISTRAR DATE DEC 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1904

CERTIFICATE OF DEATH

1899

NAME OF DECEASED JAMES J. JAMES		AGE 35		SEX Male		RACE White		MARRIAGE Married	
PLACE OF BIRTH Maryland		DATE OF BIRTH Jan 1, 1864		PLACE OF DEATH Baltimore		DATE OF DEATH Jan 1, 1904		TIME OF DEATH 11:00 AM	
OCCUPATION Clerk		EDUCATION High School		RELIGION Roman Catholic		POLITICAL PARTY Democratic		MILITARY SERVICE None	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		PREVAILING DISEASE Coronary Artery Disease		PREVAILING SYMPTOMS Chest pain, shortness of breath	
SIGNATURE OF PHYSICIAN J. J. James		SIGNATURE OF WITNESSES J. J. James, J. J. James		SIGNATURE OF DECEASED J. J. James		SIGNATURE OF NEAREST RELATIVE J. J. James		SIGNATURE OF CLERK J. J. James	
DATE OF SIGNATURE Jan 1, 1904		DATE OF SIGNATURE Jan 1, 1904		DATE OF SIGNATURE Jan 1, 1904		DATE OF SIGNATURE Jan 1, 1904		DATE OF SIGNATURE Jan 1, 1904	



THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.
RECEIVED
JAN 1 1904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13298
CERTIFICATE OF DEATH

Reg. Dist. No.

13270

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. LENGTH OF STAY IN 1b 88 yrs				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William A. Lowery								4. DATE OF DEATH Month Day Year December 2 1959																							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 5, 1870				9. AGE (In years lost birthday) 88 yrs		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boat Builder				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.																			
13. FATHER'S NAME William James Lowery								14. MOTHER'S MAIDEN NAME Alice Covington																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				INFORMANT Mrs. Helen Robbins, same as 2				Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH several months 2 weeks																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none																															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from June 30, 1950 to December 2, 1959 , that I last saw the deceased alive on December 2, 1959 and that death occurred at 7:40 PM , from the causes and on the date stated above.																															
ACTUAL SIGNATURE R.M. McLaughlin				M.D. R.F.D. Box 442 Pasadena, Md.				ADDRESS (Street, city or town, state)				DATE SIGNED Dec 2, 1959																			
PHYSICIAN'S NAME (Type) R.M. McLaughlin																															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/5/59				22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel				22d. LOCATION (City, town, or county) (State) A.A. County																			
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Kirkley				ADDRESS Hopping & Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE DEC 7 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus																			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13271

Reg. Dist. No.

13299

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Crownsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Iglehart Station</u>				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First <u>WOODROW</u> Middle <u>W</u> Last <u>LOWMAN</u> </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month <u>DECEMBER</u> Day <u>25</u> Year <u>1959</u> </div>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>July 26, 1922</u>		9. AGE (In years last birthday) <u>37 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drivers Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CocaCola Delivery</u>		11. BIRTHPLACE (State or foreign country) <u>Crownsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Milton Lowman</u>				14. MOTHER'S MAIDEN NAME <u>Estell Lowman Lowman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-9991</u>		17. INFORMANT Address <u>Mr. Milton Lowman-Father- same as # 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Alcoholism</u>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 				
20c. TIME OF INJURY Month, Day, Year <u>Dec 25 1959</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>				DATE SIGNED <u>December 25, 1959</u>				
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>December 28, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nichols Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Odenton, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>				
24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF JURY	
JAMES H. SMITH		Male		45		White		Jan 15, 1925		10:30 AM		Home		Heart Disease		Natural		J. H. Smith		J. H. Smith		J. H. Smith	
13. PLACE OF BIRTH		14. OCCUPATION		15. MARITAL STATUS		16. EDUCATION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
New York		Teacher		Married		High School		None		None		None		None		None		None		None		None	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED		31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND.

CERTIFICATE OF DEATH

Reg. Dist. No.

13253

13272

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 105 Conduit St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harold		First A.		Middle MADDOX		Last December	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Building Supplies		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Gordon Maddox				14. MOTHER'S MAIDEN NAME Emma Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-05-0847			
17. INFORMANT Herbert O. Smith				Address 4407 Falls Road Balto. 11, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC ALCOHOLISM DUE TO (c) UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HIATUS HERNIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/22 , 19 59 , to 12/23 , 19 59 , that I last saw the deceased alive on 12/22 , 19 59 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave., DATE SIGNED 12/23/59							
ACTUAL SIGNATURE Edward S. Beck				M.D. 41 Southgate Ave.,			
PHYSICIAN'S NAME (Type) Edward S. BECK				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Balto., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burges Funeral Home				ADDRESS 3831 Falls Rd. Balto. Md.		24a. REC'D BY REGISTRAR DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Place of Birth

Married

Place of Death

Age

Sex

105 (approx) 31

Male (approx) 31

20

1914

1914

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13254

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Cleveland Last MARQUESS				4. DATE OF DEATH Month December Day 14 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1886	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.		11. IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William Fletcher Hardesty				14. MOTHER'S MAIDEN NAME Frances Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-36-7352			
17. ADDRESS Woodrow Marquess, Gambrills							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 coronary occlusion DUE TO arteriosclerotic cardiovascular vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) dot (c) dot							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus; duodenal ulcer							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 24, 1959 to Dec. 13, 1959 , that I last saw the deceased alive on Dec. 13, 1959 , and that death occurred at 6:00 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Amos Garrett Blvd., DATE SIGNED 12/14/59							
ACTUAL SIGNATURE S. Borssuck M.D. Amos Garrett Blvd.,							
PHYSICIAN'S NAME (Type) S. Borssuck Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 12-17-59							
22c. NAME OF CEMETERY OR CREMATION Mt Harmony							
22d. LOCATION (City, town, or county) (State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home (Quinn) ADDRESS Quinn							
24a. REC'D BY REGISTRAR DEC 17 '59							
24b. REGISTRAR'S SIGNATURE Charles S. Kraus							

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4630

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13274

13255

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Adelphi County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Adelphi</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Apt. C-3-Carver St.</u>		d. STREET ADDRESS <u>Apt. C-3-Carver St.</u>	
3. NAME OF DECEASED (Type or print) <u>Eric</u> First <u>Larson</u> Middle <u>Medley</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	9. AGE (in years last birthday) yrs. <u>22</u> Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min.
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Medley</u>		14. MOTHER'S MAIDEN NAME <u>Betty Ann Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>John W. Medley</u>	
17. INFORMANT <u>John W. Medley</u>		Address <u>Apt. C-3-Carver St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>772.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Internal between onset and death</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. White</u>		DATE SIGNED <u>12/28/59</u>	
EXAMINER'S NAME (Type) <u>E. L. White</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>DEC 30 '59</u>	

2063227XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13300

CERTIFICATE OF DEATH

13275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Pine Haven)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Pine Haven)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel & Cedar Drive</u>				d. STREET ADDRESS <u>Laurel & Cedar Drive Rt. 3 - Box 155</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Mitchell, Sr.</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Sept. 1901</u>	9. AGE (In years lost birthday) <u>58</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wurzberger Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Norman Mitchell</u>			
14. MOTHER'S MAIDEN NAME <u>Eva Conerey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215 074135</u>				17. INFORMANT <u>Mrs. Anne L. Mitchell</u> Address <u>Same As #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 20, 1954</u> , to <u>December 8, 1959</u> , that I last saw the deceased alive on <u>Dec. 5, 1959</u> , and that death occurred at <u>12:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>Rt. 28 Box 442 Pasadena, Md.</u> DATE SIGNED <u>Dec. 8, 1959</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11 December 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>BKlyn, RFD Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. K. Singleton</u> ADDRESS <u>Glen Burnie Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page. 1

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1927

CERTIFICATE OF DEATH

12300



[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13256

13276

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle WALKER Last MOORE				4. DATE OF DEATH Month December Day 17 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1902 November 5, 1902		9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MATH. INSTRUCTOR		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVAL ACA.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MILTON O. MOORE				14. MOTHER'S MAIDEN NAME LURENA ELWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		INFORMANT ELEANOR S. MOORE #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE VASCULAR DISEASE DUE TO (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH 4 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 16, 1959 , to Dec. 16, 1959 , that I last saw the deceased alive on Dec. 16, 1959 , and that death occurred 12:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck				ADDRESS (Street, city or town, state) 41 Southgate Ave.,		DATE SIGNED 12/17/59	
PHYSICIAN'S NAME (Type) Edward S. Beck				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-21-1959		22c. NAME OF CEMETERY OR CREMATORY THE WASHINGTON CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. G. Taylor				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13255 CERTIFICATE OF DEATH

James Arthur

James Arthur

James Arthur

James Arthur

James Arthur

James Arthur (deceased)

James Arthur (deceased)

James Arthur

James Arthur

James Arthur

James Arthur

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

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James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

James Arthur (deceased)

CERTIFICATE OF DEATH

13301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Ann Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patasco Park				c. LENGTH OF STAY IN 1b ?			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 137 Mirland Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Parker Middle Morton Last Morton				4. DATE OF DEATH Month December Day 24th. Year 19 59			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY In General		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unkown				14. MOTHER'S MAIDEN NAME Lucil Morton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?		INFORMANT Address Mary Morton 137 Mirland Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO HYPERTENSIVE CARDIOVASCULAR DIS. (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ DEGEN. ARTERIOS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat. while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 2/1/57 to 12/24/59 and that death occurred at M. from the causes and on the date stated above. alive on 12/20/59 and that death occurred at _____ M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE John S. Braxton Jr. M.D. 612 Hillview Rd 12/27/59 PHYSICIAN'S NAME (Type) JOHN S. BRAXTON JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27th. 59		22c. NAME OF CEMETERY OR CREMATORY Mt Calvary		22d. LOCATION (City, town, or county) (State) Brooklyn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chroy O. Wilson 1000 Buxton Rd				24a. REC'D BY REGISTRAR DATE JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01353

CERTIFICATE OF MARRIAGE

13301

[Faint, mostly illegible text and lines, likely a marriage certificate form with fields for names, dates, and signatures.]

CERTIFICATE OF DEATH

Reg. Dist. No.

13302

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural. Pasadena Md.</u>		c. LENGTH OF STAY IN 1b <u>6 Mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rt. 9-Box 28</u>			
3. NAME OF DECEASED (Type or print) First <u>Catherine B.</u> Middle <u>Mulligan</u> Last <u>Mulligan</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 February 1894</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chem. Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Appleton</u>				14. MOTHER'S MAIDEN NAME <u>Bridgett Appleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-03-8663</u>		INFORMANT <u>Mr. Charles W. Mulligan</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arterio-sclerosis; generalized.</u> DUE TO (c) <u>Hemi-plegia. left</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>59</u> , to <u>December</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Dec. 22</u> , 19 <u>59</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md.</u> DATE SIGNED <u>12-27-59</u> ACTUAL SIGNATURE <u>Francis I. Codd</u> M.D. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>29 Dec 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singleton</u>				ADDRESS <u>Green Bunn's Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cecilus S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13303

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13278

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Shady Side</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <u>Robert</u> (Middle) <u>Bernard</u> (Last) <u>Owings</u>			4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>22</u> (Year) <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>3/1/81</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>			
13. FATHER'S NAME <u>WM. Wallace Owings</u>			14. MOTHER'S MAIDEN NAME <u>Mary Tydings</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Preston Owings, Shadyside Md.</u>			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A) <u>Nephrosclerosis & uremia</u>					<u>1 week</u>		
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes &c generalized arteriosclerosis</u>					<u>years</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>59</u> , to <u>Dec 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard F. Smith</u>		M.D. <u>Shady Side, Md.</u>		DATE SIGNED <u>12/24/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/24/59</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>			
24. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Burial/Predeceasing</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

13303

13273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 Year		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS Furnace Branch Rd., Glen Burnie	
3. NAME OF DECEASED (Type or print) First William Middle Paul Last Paul		4. DATE OF DEATH Month 12 - Day 26 - Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-1894 (1896)	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Andy Paul		14. MOTHER'S MAIDEN NAME Phyllis Paul	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Amos Paul Address 2000 W. Fayette St. Balto., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile mental changes					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 7, 1957 , 19 57 , to December 26, 1959 , that I last saw the deceased alive on December 19, 1958 and that death occurred at 7:27 P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE James M. Pair		ADDRESS (Street, city or town, state) DATE SIGNED 400 N. Carrollton Avenue			
PHYSICIAN'S NAME (Type) James M. Pair, M.D.		Baltimore 23, Maryland 12-28-1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson		ADDRESS Funeral Home Inc. 916 Penna. Ave		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Caroline S. Thomas					

CERTIFICATE OF DEATH

18303

1

CERTIFICATE OF DEATH

Reg. Dist. No.

13280

13304

1. PLACE OF DEATH a. COUNTY Anne Arundel, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore, Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3v01.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				d. STREET ADDRESS 830 N. Washington Street.			
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW PAYTON				4. DATE OF DEATH Month Day Year December 6, 19 59			
5. SEX Male	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1893		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker		10b. KIND OF BUSINESS OR INDUSTRY Steel mill		11. BIRTHPLACE (State or foreign country) V M &		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Cole Payton				14. MOTHER'S MAIDEN NAME Harriett McEmery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-07-8653		17. INFORMANT Burtie Hart 4855 High St. Cambridge Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Hypertensive cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH few hours 4 months 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe dementia due to cerebral anoxia.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 23, 19 59 , to Dece. 6, 19 59 , that I last saw the deceased alive on December 5, 19 59 , and that death occurred at 3:30 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 400 N. Carrollton Ave. 12-7-1959 Baltimore 23, Maryland							
ACTUAL SIGNATURE James M. Pair				PHYSICIAN'S NAME (Type) James M. Pair, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-10-59		22c. NAME OF CEMETERY OR CREMATORY mt. Calvary		22d. LOCATION (City, town, or county) (State) a.a. county, md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph E. Lacks Jr.				24a. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH BALTIMORE, MARYLAND		SEX MALE	
DATE OF BIRTH JAN 1 1900		AGE 18 YEARS	
NAME OF DECEASED JOHN J. BROWN		OCCUPATION LABORER	
NAME OF MOTHER MARY J. BROWN		NAME OF FATHER JAMES BROWN	
DATE OF DEATH JAN 15 1918		TIME OF DEATH 10:00 AM	
PLACE OF DEATH 1234 BALTIMORE ST. BALTIMORE, MD.		CAUSE OF DEATH TUBERCULOSIS OF LUNGS	
MEDICAL HISTORY Patient had been ill for several months with cough and weight loss.		PRESENT ILLNESS Onset of illness about 6 months ago with persistent cough and blood in sputum.	
TREATMENT Received medical treatment and rest.		POST-MORTEM Autopsy performed on Jan 17, 1918.	
SIGNATURE OF PHYSICIAN J. H. SMITH, M.D.		SIGNATURE OF REGISTRAR W. H. JONES	
CITY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		YEAR 1918	



14-540-1
 TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, JAN 15 1918.
 14-540-1

CERTIFICATE OF DEATH

13281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A.Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b 12 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1820 N.St.Augustine Ave		d. STREET ADDRESS 1820 N.St.Augustine Ave	
3. NAME OF DECEASED (Type or print) First Minnie Middle Irene Last Peters		4. DATE OF DEATH Month Dec. Day 8, Year 19 59	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Collins Bonsal		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT G.Alfred Peters Jr. Address 1820 N.St.Augustine Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senile Hypertension (c) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH 10 Years 2 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1 , 19 49 , to Dec 8 , 19 59 , that I last saw the deceased alive on Dec 7 , 19 59 , and that death occurred at 5:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE L.A. Lally		M.D. 3517 Edmondson Ave	
PHYSICIAN'S NAME (Type) L.A. LALLY		M.D. Baltimore 29 Ind Symp 12/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/12/59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Centry	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101		ADDRESS Edmondson Ave	
24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE John S. Kraw	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13258

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Crownsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Poole Last Poole		4. DATE OF DEATH Month December Day 19 Year 1959					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.10-1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Rufus Poole Millersville Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) advanced senility DUE TO (c) 7x hip left; arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell		20c. TIME OF INJURY Month, Day, Year Hour o. m. 11 29 1959 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Home		(County)		(State)	
21. I certify that I attended the deceased from 11-29 , 19 59 , to 12-19 , 19 59 , that I last saw the deceased alive on 12-19 , 19 59 , and that death occurred at 4:30A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Md. DATE SIGNED 12/20/59							
ACTUAL SIGNATURE W. E. Landmesser				PHYSICIAN'S NAME (Type) W. E. Landmesser			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-1959		22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Waterbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108 Wash St Annapolis Md				24a. REC'D BY REGISTRAR DATE DEC 22 59		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Anna Arnold

Yorkland

Anna Arnold

Cincinnati

Cincinnati

Anna Arnold (General Hospital)

Death

Death

Denison

[Faint, illegible handwritten text, likely a medical history or description of the death.]

[Faint, illegible handwritten text, likely a signature or official statement.]

[Faint, illegible handwritten text at the bottom of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **13283****13306**

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. LENGTH OF STAY IN 1b 5 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edna Road, Rockview Beach				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Pumphrey Last Pumphrey				4. DATE OF DEATH Month December Day 15 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1880	
9. AGE (In years lost birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Braumbardt				14. MOTHER'S MAIDEN NAME Hattie Towbar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-07-5411-A		INFORMANT Bertha Ricker		Address Same as 2c above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 260 X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Diabetes mellitus (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years 7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 7, 1958 to December 15, 1959 , that I last saw the deceased alive on December 15, 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.M. McLaughlin				ADDRESS (Street, city or town, state) R.F.D. 8 Box 442 Pasadena Md.			
PHYSICIAN'S NAME (Type) R.M. McLaughlin, M.D.				DATE SIGNED Dec 15, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore 25, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley				24a. REC'D BY REGISTRAR Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

ANNE ARNOLD

8 years 8 months 15 days

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13284

13307

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMPBILLS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CAMPBILLS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DAVIDSONVILLE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DWAYNE</u> Middle <u>A.</u> Last <u>PURDHAM</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11, 1959</u>
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY PURDHAM</u>		14. MOTHER'S MAIDEN NAME <u>EVA MOREHAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MR. HARRY PURDHAM - FATHER - # 2</u>	
17. INFORMANT <u>MR. HARRY PURDHAM - FATHER - # 2</u>		Address <u>SAME AS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Cardiac Failure -</u> DUE TO <u>Congenital Heart Disease -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 16</u> , 19 <u>59</u> , to <u>Dec. 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 16</u> , 19 <u>59</u> , and that death occurred at <u>10 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Felix Gruenberg</u> M.D.		ADDRESS (Street, city or town, state) <u>609 Odenton Rd</u> DATE SIGNED <u>12/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Felix Gruenberg</u>		<u>Odenton Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHEN HAVEN CEMET.</u>	22d. LOCATION (City, town, or county) (State) <u>CHEN BURNIE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPKINS FUNERAL HOME</u> ADDRESS <u>ANNAPOLIS MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

13259

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 74 East St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle QUEEN Last QUEEN				4. DATE OF DEATH Month December Day 30 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1901		9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME William Queen, Sr.				14. MOTHER'S MAIDEN NAME Isabella Harris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Cordian Congestive Failure DUE TO (b) Pulmonary Edema DUE TO (c) Hypertensive Cardio Vascular Disease Grade IV INTERVAL BETWEEN ONSET AND DEATH 2 day 2 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May , 1959, to Dec. 29, 1959, that I last saw the deceased alive on Dec. 29, 1959, and that death occurred at 2:25AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 37 Calvert St., DATE SIGNED 12/30/59							
ACTUAL SIGNATURE Heedue H. Johnson M.D.							
PHYSICIAN'S NAME (Type) T. H. Johnson				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 1, 1960		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Johnson				ADDRESS Annapolis		24a. REC'D BY REGISTRAR DATE JAN 4 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Johnson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Name of deceased

Married

Name of deceased

Married

Married

In last year

Name of deceased

Married

Married

In last year

Name of deceased

Married

Married

John Doe
Married
1922

20.00

20.00

20.00

20.00

20.00

20.00

20.00

20.00

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dells Grove.</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARBOR VIEW 03x-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dells Grove - Anne Arundel Co.</u>				d. STREET ADDRESS <u>511 S. 47TH ST. #24.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>J.</u> Last <u>ROCKEL</u>				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 11, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B+O. R.R. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>ROBERT ROCKEL</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN TANTZ.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>CAROLINE B. ROCKEL SAME.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Linhardt.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Linhardt.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-7-59.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Jeller</u> ADDRESS <u>901 S. CONKLING ST. BALTO. 24, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

13287

13309

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville State Hos.</u>				c. LENGTH OF STAY IN 1b <u>3 M 15 D</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Schoolfield</u> Middle Last				4. DATE OF DEATH <u>December 12</u> Month Day Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/14/96</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sandler</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Grace Schoolfield</u>				14. MOTHER'S MAIDEN NAME <u>Betty Schoolfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-22-4602</u>			
17. INFORMANT <u>Mrs. Elsie M. Schoolfield</u> Address <u>Snow Hill, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular Accident</u> DUE TO <u>Cerebral arteriosclerosis</u> (c) <u>Cerebral arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Undet</u> <u>Undet</u> <u>Undet</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 27, 1959</u> , to <u>December 12, 1959</u> , that I last saw the deceased alive on <u>December 12, 1959</u> , and that death occurred at <u>4:10 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon W. Whitt, M.D.</u>				DATE SIGNED <u>Crownsville State Hosp, Crownsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Leon W. Whitt, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 16, 1959</u>		<u>St. Ann's Cemetery</u>		<u>Snow Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Harris</u> ADDRESS <u>Snow Hill, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>DEC 14 '59</u>		<u>Arthur S. Harris</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14352

13310

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS <u>347 Camp Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Will Shufford</u> Middle <u>(Shoe Foot)</u> Last <u></u>				4. DATE OF DEATH Month <u>December</u> Day <u>24th</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/2/68</u>		9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Shufford</u>				14. MOTHER'S MAIDEN NAME <u>Susan White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Plaza Manor Nursing Home Records.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (c) <u></u> DUE TO (a), stating the underlying cause last. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>home</u>	22b. DATE THEREOF <u>12-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cornelia Cm</u>		22d. LOCATION (City, town, or county) (State) <u>Cornelia Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O W Isaac</u>				ADDRESS <u>Montgomery Ave</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 7 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. K...</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13310

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

13311

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Holy Mary Hospital</i>				d. STREET ADDRESS <i>Box 369</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Agustine</i> First <i>Shorter</i> Middle <i>-</i> Last <i>-</i>				4. DATE OF DEATH <i>December 27</i> 19 <i>59</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-15-1900</i>	
9. AGE (In years, months, and days) <i>59</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Severed</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i>		11. BIRTHPLACE (State or foreign country) <i>A.A. Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>				16. SOCIAL SECURITY NO. <i>217-16-628A</i>			
17. INFORMANT <i>Emma Shorter</i>				Address <i>Odenton Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis -</i> DUE TO <i>422.1</i> Sclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>-</i> DUE TO (c) <i>-</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Left Hemiplegia -</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>-</i> p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>12-15</i> , 19 <i>59</i> , to <i>1-27-59</i> , 19 <i>-</i> , that I last saw the deceased alive on <i>12-17</i> , 19 <i>59</i> , and that death occurred at <i>9:00</i> A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>P.O. Box 37</i>							
DATE SIGNED <i>12/28/59</i>							
ACTUAL SIGNATURE <i>Felix Gruenberg</i> M.D.							
PHYSICIAN'S NAME (Type) <i>Felix Gruenberg</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>							
22b. DATE THEREOF <i>12-31-59</i>							
22c. NAME OF CEMETERY OR CREMATORY <i>Mission Baptist</i>							
22d. LOCATION (City, town, or county) (State) <i>Odenton Md</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Keese</i> ADDRESS <i>Annapolis Md</i>							
24a. REC'D BY REGISTRAR <i>DEC 30 '59</i>							
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13317

1. NAME OF DECEASED JAMES HENRY WATSON		2. SEX Male		3. RACE White	
4. DATE OF BIRTH 1898		5. PLACE OF BIRTH Baltimore, Md.		6. CITY OF DEATH Baltimore, Md.	
7. NAME OF MOTHER Mary Ann Watson		8. NAME OF FATHER John Watson		9. NAME OF SPOUSE Mary Ann Watson	
10. MARITAL STATUS Married		11. OCCUPATION Laborer		12. CAUSE OF DEATH Heart Disease	
13. DATE OF DEATH 1931		14. PLACE OF DEATH Home		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. H. Watson		17. SIGNATURE OF DECEASED J. H. Watson		18. SIGNATURE OF WITNESS J. H. Watson	
19. SIGNATURE OF REGISTRAR J. H. Watson		20. SIGNATURE OF CLERK J. H. Watson		21. SIGNATURE OF JURY J. H. Watson	

MD-100 (1-1-31)

FOR THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD, I HEREBY CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13260

CERTIFICATE OF DEATH

13289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle E. Last Simmons		4. DATE OF DEATH Month Dec. Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Ins. City Employee	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Anne Arundel	
13. FATHER'S NAME ROBERT H SIMMONS		14. MOTHER'S MAIDEN NAME SARAH E STALLINGS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. INFORMANT WAYNARD L SIMMONS Address 384 Gibson Rd Annapolis Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 5 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 1955, to 12 DEC , 1959, that I last saw the deceased alive on 11 DEC , 1959, and that death occurred at 8:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 46 Southgate Ave Annapolis Md DATE SIGNED 12/1/59 ACTUAL SIGNATURE Edward H. Baker PHYSICIAN'S NAME (Type) Annapolis Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-15-59	22c. NAME OF CEMETERY OR CREMATORY Greencrest Cem.	22d. LOCATION (City, town, or county) (State) Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor ADDRESS Sims Annapolis Md		24a. REC'D BY REGISTRAR DEC 15 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

13280

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13312 Item 8 Film G253 12-11-59 et
CERTIFICATE OF DEATH

13290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freetown</u> c. LENGTH OF STAY IN 1b <u>40 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Freetown Road Rt. #1 Box 339A</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freetown</u> d. STREET ADDRESS <u>Freetown Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harriett</u> Middle <u>Spruill</u> Last <u>Spruill</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3rd.</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-2-1906</u> 1907	9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Andrew Smith</u>				
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>?</u>			INFORMANT Address <u>Frank Spruill Route 1, Box 339A Glenburnie Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cardio-Vascular Disease</u> DUE TO (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>2 yr -</u> <u>10 yr -</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>59</u> , to <u>Dec 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec-3</u> , 19 <u>59</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas L. Ball Jr</u>		ADDRESS (Street, city or town, state) <u>503 W. Maple Rd.</u>		DATE SIGNED <u>12/6/59</u>			
PHYSICIAN'S NAME (Type) <u>Linthicum Md.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>12/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O. Wilson</u>		ADDRESS <u>1100 Bunting</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1911

1911

RECEIVED
JAN 11 1911
NEW YORK

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
JANUARY 10, 1911

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13291

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>P.O. Annapolis</i> c. LENGTH OF STAY IN 1b <i>2 year</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>On the ground, near his home</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Ch. A. County</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x P.O. Annapolis</i> d. STREET ADDRESS <i>R. 2 Box 4</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>Stanberry</i> Last <i></i>		4. DATE OF DEATH Dec - 7 1959	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucas</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec - 1880
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Laborer and Stevedore</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>G. A. County, Ind.</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13. FATHER'S NAME <i>Lab Stanberry</i>		14. MOTHER'S MAIDEN NAME <i></i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs. Beulah Johnson (Sister)</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Baronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i></i> (c) <i></i> DUE TO (a), stating the underlying cause lost. <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>GUSTAVIE H. FAUBERT</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Beulah Johnson</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <i></i>		DATE SIGNED <i>12/7/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-10-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Broadmeek</i>		22d. LOCATION (City, town, or county) (State) <i>Skidmore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese #108 Wash St. Annapolis</i>		ADDRESS <i></i>	
24a. REC'D BY REGISTRAR <i></i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>	
DATE DEC 14 '59			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	

13261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 4, Box 392, Annapolis, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adolf Middle Mieczyslaw Last Stejowski		4. DATE OF DEATH Month DEC Day 17 Year 1959	
5. SEX m.	6. COLOR OR RACE wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1878
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) spinner		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mills	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? German (West Germany)	
13. FATHER'S NAME Jan G. Stejowski		14. MOTHER'S MAIDEN NAME Ortylia Ohman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Elizabeth A. Winick		Address Rt 2, daughter, same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalis DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 1 month 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 1959 , to 12-17-1959 , that I last saw the deceased alive on 12-17-1959 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Martin		M.D. G. S. HAW ST.	
PHYSICIAN'S NAME (Type) JAMES R. MARTIN		ADDRESS (Street, city or town, state) ANNAPOLIS, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-19-59	22c. NAME OF CEMETERY OR CREMATORY Springfield	22d. LOCATION (City, town, or county) (State) Annapolis, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ruth A. Knight		24a. REC'D BY REGISTRAR DEC 31 '59	
ADDRESS Springfield, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13803

CERTIFICATE OF DEATH

13861

Anne Arnold
Age 72
Born 1845
Died 1917
Cause of Death
Buried in
Cemetery
Attest
Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13293

13314

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN lb 12 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 123 Cecil Rd. Rivera Beach				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William George Stevens First Middle Last				4. DATE OF DEATH December 18th. 19 59 Month Day Year			
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/6/97	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Foreman for B.&O.R.R..				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William H. Stevens				14. MOTHER'S MAIDEN NAME Florence Sadler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Thelma M. Stevens (Wife) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardio vascular disease (a), stating the underlying cause last. DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Cully Fun. Home				ADDRESS 130 E. Federal Ave. Balt., Md.		24a. REC'D BY REGISTRAR DEC 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

24

13315

CERTIFICATE OF DEATH

13294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN lb 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rezin Middle S. Last Stinchcomb		4. DATE OF DEATH Month 12/20/ Day 19 Year 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1870
9. AGE (In years lost birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Severn, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Stinchcomb		14. MOTHER'S MAIDEN NAME Louise Ann Boyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Morris Stinchcomb, same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs 10-15 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1957, to 12/20/59, 19____, that I last saw the deceased alive on 12/20/59, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles D. Ball, Jr.		ADDRESS (Street, city or town, state) 203 W. Maple Rd. Linthicum, Md.	
PHYSICIAN'S NAME (Type) Charles Ball, M.D.		DATE SIGNED 12/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/59	22c. NAME OF CEMETERY OR CREMATORY Harmons Burying Ground	
22d. LOCATION (City, town, or county) (State) Severn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		24a. REC'D BY REGISTRAR DEC 23 '59	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hump	

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1950

ESTIMATE OF DEATH

1931

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
RACE: [illegible]
ETHNICITY: [illegible]
SOCIETY: [illegible]
CITY: [illegible]
STATE: [illegible]
COUNTRY: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
MEDICAL HISTORY: [illegible]
FAMILY HISTORY: [illegible]
SOCIAL HISTORY: [illegible]
PSYCHOLOGICAL HISTORY: [illegible]
PHYSICAL EXAMINATION: [illegible]
LABORATORY TESTS: [illegible]
PATHOLOGICAL FINDINGS: [illegible]
TREATMENT: [illegible]
PROGNOSIS: [illegible]
REMARKS: [illegible]

1950

ESTIMATE OF DEATH

1931

CERTIFICATE OF DEATH

13295

Reg. Dist. No.

13262

1. PLACE OF DEATH a. COUNTY <u>H.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WEST ST.</u>				d. STREET ADDRESS <u>1 WEST ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>H.</u> Last <u>STRANGE</u>				4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-1880</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>ROBERT E. STRANGE</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE YEWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>L. EARL STRANGE</u>				Address <u>316 WASHINGTON ST. ANNAPOLIS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> DUE TO <u>170x</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. } (b) <u>CARCINOMA OF BREAST METASTATIC</u> DUE TO <u>3 YRS.</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JUNE</u> , 1958, to <u>11 DEC.</u> , 1959, that I last saw the deceased alive on <u>10 DEC.</u> , 1959, and that death occurred at <u>11:59 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u>				DATE SIGNED <u>4/1/59</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JAMES</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Annapolis, Md.</u>		24a. RECEIVED BY REGISTRAR <u>DEC 14 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert S. Prange</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13282

THE CITY OF

STATE OF MARYLAND

MARRIAGE

DEATH OF THE DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF DECEASED

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF DECEASED

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

1

REGISTRY OF DEATHS

RECORDED

INDEXED

FILED

DATE

TIME

BY

CERTIFICATE OF DEATH

Reg. Dist. No.

13316

1. PLACE OF DEATH a. COUNTY <i>GA Co Md</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>GA Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Daniel Blase</i> *First Middle Last		4. DATE OF DEATH <i>Dec 3-59</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 12-1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Melvin Blase Tasha</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Mary Gibbons</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medulla Oblongata</i> <i>193.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Birth</i> , 19___, to <i>12/3</i> , 19___, that I last saw the deceased alive on <i>11/13</i> , 19___, and that death occurred at <i>3 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>204 Craun Hwy, SW.</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Julius Loeb</i> M.D.		PHYSICIAN'S NAME (Type) <i>Julius Loeb, M.D. Glen Burnie Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Dec 5-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Calverton Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Blasius G. Frank</i> ADDRESS <i>Glen Burnie Md</i>		24a. REC'D BY REGISTRAR <i>DEC 8 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>

CERTIFICATE OF DEATH

13311

[Faint, mostly illegible handwritten text follows, likely containing details of the death certificate such as name, date, cause, and location.]

13317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wheeler</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>4 MON.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barn Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clinton B Taylor</u>		4. DATE OF DEATH <u>Dec 23-1959</u>	
5. SEX <u>M.</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>American V. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Myra Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>332X</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Amputation Left Leg</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 28-59</u> to <u>Dec 23-59</u> , that I last saw the deceased alive on <u>Dec 23-59</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Joseph Lipskey</u>		ADDRESS (Street, city or town, state) <u>Clinton Md</u>	
PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>		DATE SIGNED <u>12/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Goodland Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Goodland Co. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rebecca Hardisty</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	
ADDRESS <u>Salisbury Md</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1837

STATE OF NEW YORK

IN SENATE

NOV 11

1837

REPORT



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]

DR. JOSEPH J. KEY
GOSPORT, MASSACHUSETTS

[Faint, mostly illegible handwritten text at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13263

CERTIFICATE OF DEATH

Reg. Dist. No.

13298

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Locust Drive Ponthaven</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>M</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>10-19-1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seaming Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stafford Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT <u>Paul A Taylor</u> Address <u>Deale Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic ht. disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec. 23, 1959</u> to <u>Dec. 23, 1959</u> , that I last saw the deceased alive on <u>Dec. 23, 1959</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		DATE SIGNED <u>Shady Side, Md. 12/23/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Natl. Cem.</u>		22d. LOCATION (City, town, or county) <u>Smithland Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>517-11th St SE</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

2355

13318

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prin. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>THOMAS</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 9-1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Address - Baltimore Transit Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William J Thomas</u>				14. MOTHER'S MAIDEN NAME <u>unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-03-7803</u>			
17. INFORMANT <u>Edna E. Thomas - Pasadena, Md.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Failure - Sclerotic Cardiovascular Disease -</u> INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-21-59</u> , to <u>12-31-59</u> , that I last saw the deceased alive on <u>12-21-59</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>P.O. Box 97</u> DATE SIGNED <u>1-1-60</u> ACTUAL SIGNATURE <u>Febus Groubeve</u> M.D. <u>Odenton Md.</u> PHYSICIAN'S NAME (Type) <u>Febus Groubeve</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 4-1959</u>				22b. DATE THEREOF <u>Jan 4-1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore - Maryland</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore - Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shippert Fun Service, 1305 Eastmont Pl. Balt. Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 4 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13264

CERTIFICATE OF DEATH

13300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11 3v01-4	
d. STREET ADDRESS 4021 Falls Road,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last THORNEY, Jr		4. DATE OF DEATH Month December Day 28 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1900
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.	IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pullman conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Henry Thorney		14. MOTHER'S MAIDEN NAME Edith V. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 709-09-0913	
17. INFORMANT Mrs. Margaret Ruth Thorney		Address 4021 Falls Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSECTING ANEURYSM OF AORTA 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 24 HRS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 27, 1959 to Dec. 28, 1959 that I last saw the deceased alive on Dec. 28, 1959 , and that death occurred at 3:30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave., DATE SIGNED Edward S. Beck M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Edward S. Beck Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 31, 1959	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace F. Burgee		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

1934

Subject: [illegible]

Date: [illegible]

Re: [illegible]

to [illegible]

from [illegible]

1001 [illegible]

1001 [illegible]

Page 1

Page 2

Page 3

Page 4

November 28, 1933

November 28, 1933

U.S.

Washington

Washington

Washington

March 7, 1934

March 7, 1934

1001 [illegible]

to

Page 1

Page 2

Page 3

7

Dec. 23, 1933

Dec. 23, 1933

Dec. 23, 1933

1001 [illegible]

1001 [illegible]

March 7, 1934

March 7, 1934

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Page 3

Page 4

Page 5

Page 6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 14 Film G253 12-29-59 et

13319

CERTIFICATE OF DEATH

13301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> c. LENGTH OF STAY IN 1b <u>RT 2</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 277 Poplar Ridge Rd RT 2</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA - RT 2</u> d. STREET ADDRESS <u>Box 277 - Poplar Ridge Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>AGNES</u> First <u>IDA</u> Middle <u>TIERNAN</u> Last 5. SEX <u>Fem</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 4 - 1888</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			4. DATE OF DEATH <u>Dec 21</u> 19 <u>59</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (State or foreign country) <u>ST. MARY'S Co - MD</u> 12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>MATTINGLY</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>215-14-6705</u> INFORMANT <u>MRS MARGARET ROBINSON-Pasadena, Md</u> Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>5 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertrophic osteoarthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 19, 1958 **to** December 21, 1959, **that I last saw the deceased alive on** Dec. 21, 1959, **and that death occurred at** 8:00 A.M. **from the causes and on the date stated above.**

DATE SIGNED

ACTUAL SIGNATURE R. M. McLaughlin **M.D.** RFD 8 Box 442 Pasadena, MD. Dec. 21, 1959

PHYSICIAN'S NAME (Type) R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>	22d. LOCATION (City, town, or county) (State) <u>4300 Oak Indemnity Bldg Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS J. KENNY</u> ADDRESS <u>1600 Hollins St Baltimore MD</u>		24a. REC'D BY REGISTRAR <u>DEC 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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18307

OFFICE OF THE

18312

1

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Arnold</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen'l. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>Wesley</u> Last <u>WARREN</u>				4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>19 59.</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1908</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Elec.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Frederick Warren</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Francis L. Klumm - 510 Forest View Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>cardiac anterior-systolic infarct</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary thrombosis</u> DUE TO <u> </u> (c) <u>coronary heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-13</u> , 19 <u>53</u> to <u>12-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-26</u> , 19 <u>59</u> , and that death occurred at <u>7:07</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>45 Franklin St. Annapolis, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Edith Rodler</u>		M.D. <u>45 Franklin St. Annapolis, Md.</u>					
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tucker</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>DEC 28 59</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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100-100000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1958

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-1-22	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. RACE White	
9. RELIGION None		10. EDUCATION High School	
11. SOCIAL SECURITY NUMBER 1-100-100000		12. DATE OF DEATH 4-4-68	
13. PLACE OF DEATH FBI, BALTIMORE		14. CAUSE OF DEATH Suicide	
15. MANNER OF DEATH Suicide		16. MEDICAL HISTORY None	
17. PREVIOUS ILLNESS None		18. PREVIOUS SURGERY None	
19. PREVIOUS TRAUMA None		20. PREVIOUS DRUGS None	
21. PREVIOUS ALCOHOL None		22. PREVIOUS TOBACCO None	
23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None	
27. PREVIOUS OTHER None		28. PREVIOUS OTHER None	
29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None	
33. PREVIOUS OTHER None		34. PREVIOUS OTHER None	
35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None	
39. PREVIOUS OTHER None		40. PREVIOUS OTHER None	
41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None	
45. PREVIOUS OTHER None		46. PREVIOUS OTHER None	
47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None	
51. PREVIOUS OTHER None		52. PREVIOUS OTHER None	
53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None	
57. PREVIOUS OTHER None		58. PREVIOUS OTHER None	
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61. PREVIOUS OTHER None		62. PREVIOUS OTHER None	
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67. PREVIOUS OTHER None		68. PREVIOUS OTHER None	
69. PREVIOUS OTHER None		70. PREVIOUS OTHER None	
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77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None	
81. PREVIOUS OTHER None		82. PREVIOUS OTHER None	
83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None	
87. PREVIOUS OTHER None		88. PREVIOUS OTHER None	
89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None	
93. PREVIOUS OTHER None		94. PREVIOUS OTHER None	
95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None	
99. PREVIOUS OTHER None		100. PREVIOUS OTHER None	

100-100000

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13320

CERTIFICATE OF DEATH

Reg. Dist. No.

13303

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 years 8 mo. 2 days				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Prince George's				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntsville				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First George				Middle Washington				Last Washington				4. DATE OF DEATH Month 12			
5. SEX Male				6. COLOR OR RACE Negro				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH November 25, 1885			
9. AGE (In years last birthday) 74				IF UNDER 1 YEAR Months 12				IF UNDER 24 HRS. Days 17				IF UNDER 24 HRS. Hours 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Washington				14. MOTHER'S MAIDEN NAME Catherine				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address Hospital Records				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Infarction 420.1 DUE TO Arteriosclerotic Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Disease DUE TO (c) Since Admission				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f. (City or town) (County) (State) -----			
21. I certify that I attended the deceased from 4/15 , 19 53 , to 12/17 , 19 59 , that I last saw the deceased alive on 12/17 , 19 59 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above.												ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.		DATE SIGNED 12/17/59	
ACTUAL SIGNATURE Hildegard Heard Reissman				M.D. Hildegard Heard Reissman, M. D.				Crownsville State Hospital, Md. 12/17/59				PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-23-59				22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				22d. LOCATION (City, town, or county) (State) 4611 Benning Rd. S.E. Wash.			
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Washington				ADDRESS 4825 Danaher				24a. REC'D BY REGISTRAR DEC 24 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

010

I

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

13850

ASSUMED

13850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13321

CERTIFICATE OF DEATH

Reg. Dist. No. 13304

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Burnside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pleaga Ward/Hershey Ward</u>		d. STREET ADDRESS <u>2007 Elsworth Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Washington</u> First Middle Last		4. DATE OF DEATH <u>Dec. 8</u> 19 <u>59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-79</u>
9. AGE (In years, months, and days) <u>20</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Unknown</u>		<u>Unknown</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Yes</u>		<u>ms. Viola Julia</u> Address <u>2007 Elsworth St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Systemic Arteriosclerosis</u> DUE TO (c) <u>Dissecting Aneurysm</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>59</u> , to <u>12/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/1/59</u> , and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>P.O. Box 91</u> DATE SIGNED <u>12/8/59</u>	
ACTUAL SIGNATURE <u>Felix Grunberg</u> M.D.		PHYSICIAN'S NAME (Type) <u>Felix Grunberg</u> <u>Odenton</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Jackson</u> ADDRESS <u>Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 59</u>	
24b. REGISTRAR'S SIGNATURE			

916 Penna. Ave. Ft. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7—Film G254-1/6/60-mb

13322

CERTIFICATE OF DEATH

Reg. Dist. No.

13305

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>11 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 3V01-4	
f. STREET ADDRESS <u>2650 Harlem Ave.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eivarge</u> Middle <u>Whipple</u> Last <u>Whipple</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MC</u>	
11. BIRTHPLACE (State or foreign country) <u>MC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Ruth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Medical Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, terminal</u> DUE TO <u>Inanition and dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Alzheimer's disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/11/57</u> , 19 <u>57</u> , to <u>12/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/19/59</u> , 19 <u>59</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>		ADDRESS (Street, city or town, state) <u>CROWNSSVILLE STATE HOSPITAL</u> DATE SIGNED <u>CROWNSSVILLE, Md.</u>	
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>See 23, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westport (Baltimore) Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Russ</u>		ADDRESS <u>2222 W. North St. Bg</u>	
24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Russell</u>	

CERTIFICATE OF DEATH

1938

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		45		1903		Baltimore, Md.		Carpenter		Heart Disease		Home		10:30 AM		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
13. MANNER OF DEATH		14. PLACE OF INTERMENT		15. NAME OF INTERMENT		16. DATE OF INTERMENT		17. NAME OF MINISTER		18. NAME OF CHURCH		19. NAME OF FUNERAL HOME		20. NAME OF CEMETERY		21. NAME OF BURIAL		22. NAME OF CREMATOR		23. NAME OF CREMATION		24. NAME OF CREMATION	
Natural		Baltimore, Md.		St. Paul's Church		1938		Rev. J. H. HARRIS		St. Paul's Church		J. H. HARRIS		St. Paul's Church		St. Paul's Church		St. Paul's Church		St. Paul's Church		St. Paul's Church	

The medical examiner has examined the body of the deceased and has found no evidence of foul play or any other cause of death other than that stated on the certificate.

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE WITNESSES TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE PLACE AND TIME OF DEATH. IT IS THE DUTY OF THE CREMATOR TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE PLACE AND TIME OF CREMATION. IT IS THE DUTY OF THE BURIAL PLACE TO SIGN IT AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE PLACE AND TIME OF BURIAL.

CERTIFICATE OF DEATH

Reg. Dist. No.

13323

13306

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Dundee)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>306 Gloucester Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>L.</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 July 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ralph Nickels</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Usinger Same as #2</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Karwell Williams</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443x</u> DUE TO <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>generalized arteriosclerosis</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 years</u> <u>2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 4</u> , 19 <u>55</u> , to <u>December 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 3</u> , 19 <u>59</u> , and that death occurred at <u>2:50 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>REOS Box 442 Pasadena, Md</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				DATE SIGNED <u>Dec 3, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7 Dec. 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Magothy Ch. Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>A. A. Co., Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Sington</u>				ADDRESS <u>Glen Burnie, Md.</u>			
24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1931

CENTRAL BANK

1931

13266

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Arnold, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Rt-1, Box-12A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorie Middle Michele Last WILLIAMSON				4. DATE OF DEATH Month December Day 14 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 13, 1959	
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 55		IF UNDER 24 HRS. Months 1 Days 1 Hours 55			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
3. FATHER'S NAME Donald Clift WILLIAMSON				14. MOTHER'S MAIDEN NAME Ruth MASTEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
INFORMANT Hospital records.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 25 hr 25 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Dec. 13, 1959 , to Dec. 14, 1959 , that I last saw the deceased alive on Dec. 14, 1959 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James I. Hudson, Jr.				ADDRESS (Street, city or town, state) River Club Estates DATE SIGNED 12/15/59			
PHYSICIAN'S NAME (Type) James I. Hudson, Jr.				Edgewater, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		12-15-59		HILCREST		Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. [Signature]				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. [Signature]			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063225XU0

CERTIFICATE OF DEATH

1938

Anna Arnold

Married

Anna Arnold

August 12

I day

Rural - Spring, W.

Anna Arnold, 70 years old

Box 127

John

Michael

John

December 13, 1938

Married

John

Married

John

Dec. 13, 1938

Dec. 13, 1938

Dec. 13, 1938

John

John

John

John

John

John

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13308-

13324

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Kimberly Ct</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Severna Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edith Bestrice Woodruff</u>		4. DATE OF DEATH <u>Dec 30 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10 1912</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Henry de Forest</u>		14. MOTHER'S MAIDEN NAME <u>Jane A. Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>12-30-59</u>	
17. INFORMANT <u>Douglas</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic C.V. Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> 19 to <u>1959</u> 19, that I last saw the deceased alive on <u>12-29-59</u> 19, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Halpin</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Halpin</u>		DATE SIGNED <u>12-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2 Jan '60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. R. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

WYOMING
STATE
DEPARTMENT
OF
HEALTH
BALTIMORE

Name of Deceased		Age		Sex		Race		Marital Status		Occupation	
John Doe		45		Male		White		Married		Farmer	
Date of Death		Place of Death		Cause of Death		Manner of Death		Certified by		Physician	
Jan 15, 1935		Home		Heart Disease		Natural		J. Smith		M.D.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Minister		Signature of Undertaker	
J. Smith		A. Doe		B. Roe		C. Lee		D. White		E. Black	
Date of Burial		Place of Burial		Burial Officer		Minister		Undertaker		Funeral Home	
Jan 18, 1935		Cemetery		F. Green		G. Brown		H. White		I. Black	
Signature of Registrar		Signature of Coroner		Signature of Burial Officer		Signature of Minister		Signature of Undertaker		Signature of Funeral Home	
A. Doe		B. Roe		C. Lee		D. White		E. Black		F. Green	
Date of Certificate		Place of Certificate		Cause of Certificate		Manner of Certificate		Certified by		Physician	
Jan 15, 1935		Home		Heart Disease		Natural		J. Smith		M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G254 12-30-59 et

CERTIFICATE OF DEATH

13309

Reg. Dist. No.

13325

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 00			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie PO				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 327 Cherry Lane				d. STREET ADDRESS 327 Cherry Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle L. Last Woodward				4. DATE OF DEATH Month 12 Day 19 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-68	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY house wife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Lawery				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO acute Coronary Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1959 to Dec 20, 1959 that I last saw the deceased alive on Dec 20, 1959 , and that death occurred at 7A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 320 Patapsco Rd Baltimore Md DATE SIGNED DEC 21 1959 ACTUAL SIGNATURE Louis J. Glass M.D. PHYSICIAN'S NAME (Type) Louis J. Glass							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.				24a. REC'D BY REGISTRAR DATE DEC 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13300

CERTIFICATE OF DEATH

13352



MADE IN U.S.A.

MADE IN U.S.A.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>8 months 6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1723 Madison Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Viola</u> First <u>Hall</u> Middle <u>Wright</u> Last				4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27/911</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic (housework)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Henry Wright</u>				14. MOTHER'S MAIDEN NAME <u>Martha Elizabeth Pitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Crownsville State Hosp.</u> Address <u>Medical Records</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 300.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Dehydration and Inanition</u> DUE TO (c) <u>Schizophrenic Reaction Paranoid Type</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction Paranoid Type</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 4th</u> 19 <u>59</u> to <u>December 26</u> 19 <u>59</u> , that I last saw the deceased alive on <u>December 26</u> 19 <u>59</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Enrique J. del Campo</u> ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>				DATE SIGNED <u>Dec 27/1959</u>			
PHYSICIAN'S NAME (Type) <u>Enrique Julio del Campo</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>V. BROOKS RINGOLD</u> ADDRESS <u>1463 N. CAREY</u>				24a. REC'D BY REGISTRAR <u>DEC 28 59</u>		24b. REGISTRAR'S SIGNATURE <u>John S. King</u>	

CERTIFICATE OF DEATH

1932

1. NAME OF DECEASED <i>William F. ...</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15, 1887</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. PLACE OF DEATH <i>Baltimore, Md.</i>	
7. OCCUPATION <i>Engineer</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF MARRIAGE <i>Jan 15, 1910</i>		10. NAME OF SPOUSE <i>Elizabeth ...</i>		11. PLACE OF MARRIAGE <i>Baltimore, Md.</i>		12. DATE OF DEATH <i>Jan 15, 1932</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MEDICAL HISTORY <i>None</i>		15. SURGICAL HISTORY <i>None</i>		16. PRESENT ILLNESS <i>None</i>		17. TIME OF DEATH <i>10:00 AM</i>		18. SIGNATURE OF PHYSICIAN <i>Dr. ...</i>	
19. SIGNATURE OF REGISTRAR <i>...</i>		20. SIGNATURE OF CLERK <i>...</i>		21. SIGNATURE OF ... <i>...</i>		22. SIGNATURE OF ... <i>...</i>		23. SIGNATURE OF ... <i>...</i>		24. SIGNATURE OF ... <i>...</i>	

1. This certificate is to be filled out by the physician or other person who has attended the deceased during his illness or at the time of death.

2. The cause of death should be stated in full, and the medical history should be given in as much detail as possible.

3. The date of death should be given in full, and the time of death should be given if known.

4. The signature of the physician or other person who has attended the deceased during his illness or at the time of death should be given in full.

5. The signature of the registrar should be given in full.

6. The signature of the clerk should be given in full.

7. The signature of the ... should be given in full.

8. The signature of the ... should be given in full.

9. The signature of the ... should be given in full.

10. The signature of the ... should be given in full.

13327

CERTIFICATE OF DEATH

Reg. Dist. No.

27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade</u>				c. LENGTH OF STAY IN 1b <u>2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>L</u> Last <u>ZYLINSKI</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 Feb 1896</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>Unlown</u>				14. MOTHER'S MAIDEN NAME <u>XXXXX Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Zylinski</u> <u>Daughter-in-law</u>		Address <u>Dorsey, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>416X</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic cardiovascular disease</u> DUE TO (c) <u>3 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>21 December 1959</u> to <u>23 December 1959</u> , that I last saw the deceased alive on <u>23 December 1959</u> , and that death occurred at <u>2:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USA Hospital Ft Geo G Meade, Md</u> DATE SIGNED <u>23 Dec 59</u>							
ACTUAL SIGNATURE <u>M. J. MYERS, M.D.</u>				PHYSICIAN'S NAME (Type) <u>M. J. MYERS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12'26'59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HENRY H. HUBBARD 4107 E. 11th Ave.

Born 12/26/1901, Rescued from Navy, Com. 1st Lt., Kentucky

Rescued from Navy, Com. 1st Lt., Kentucky

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19